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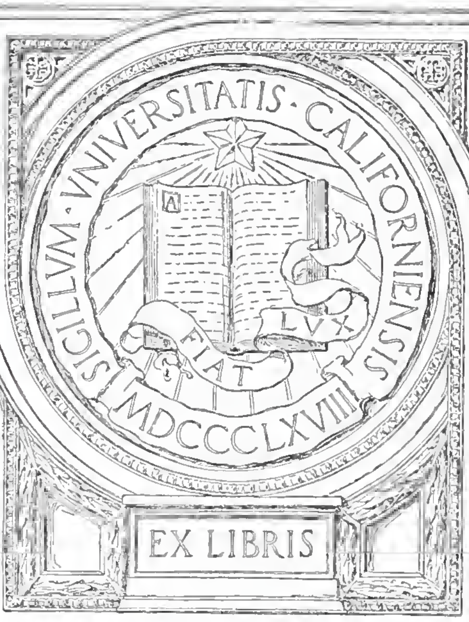

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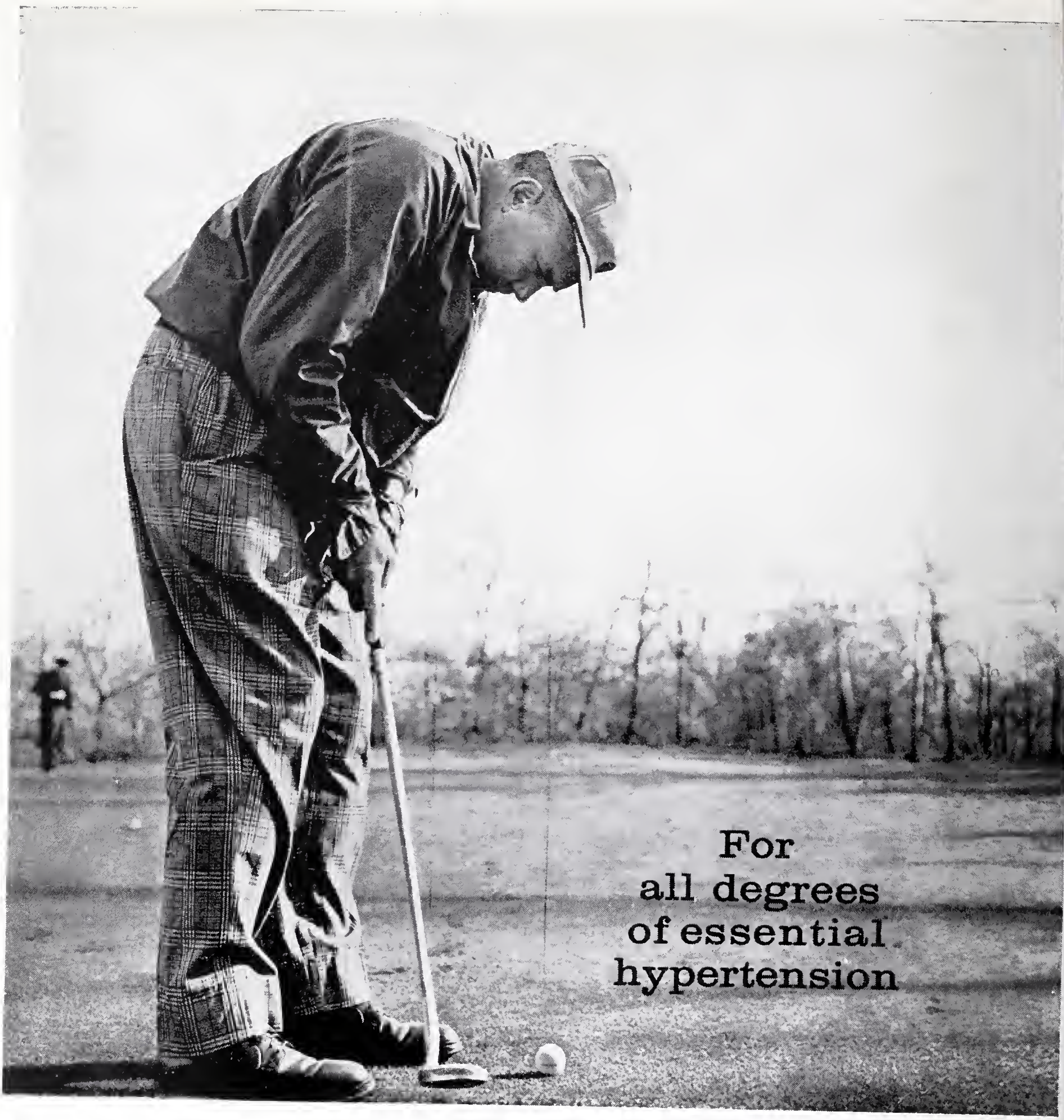

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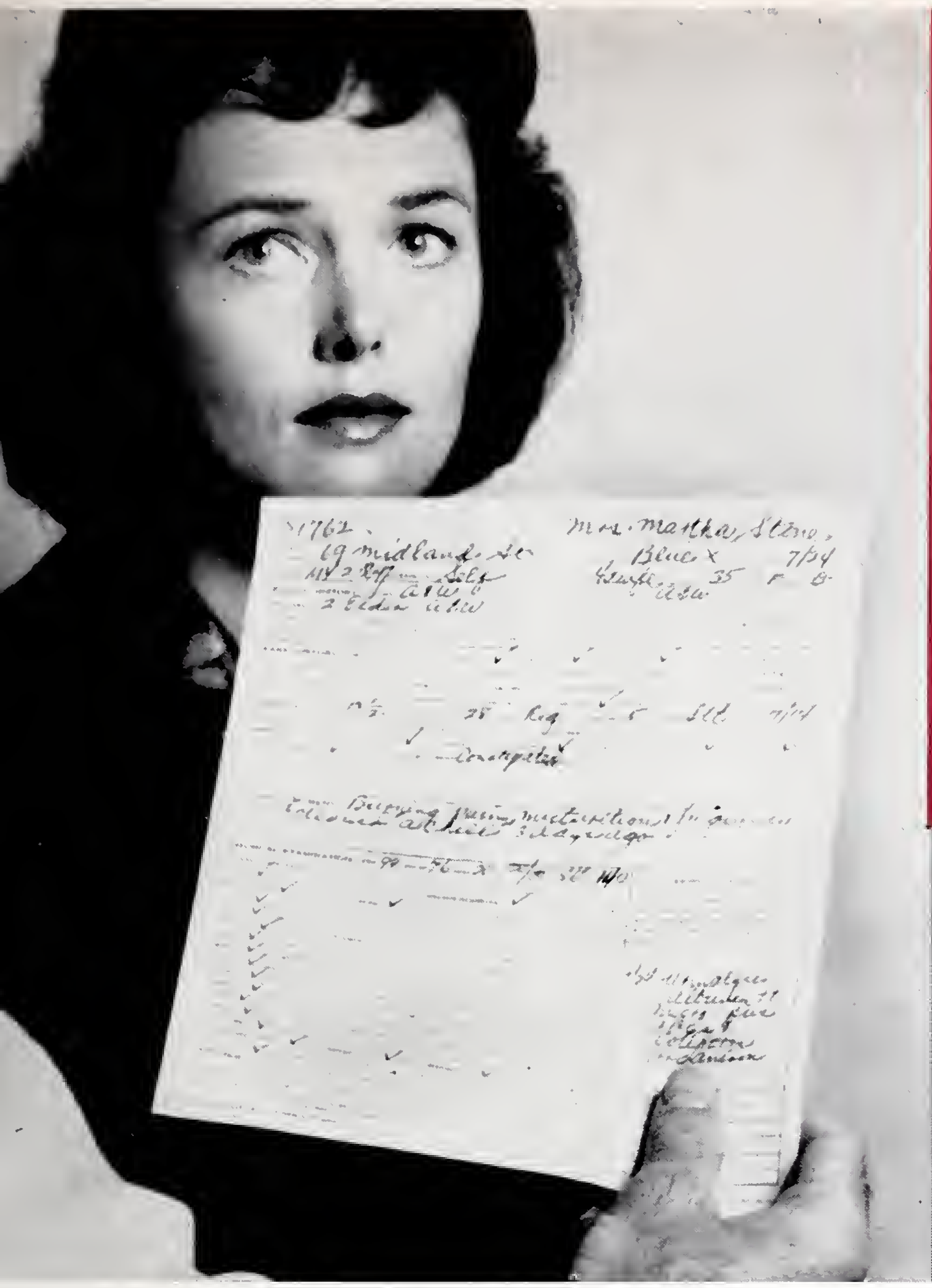

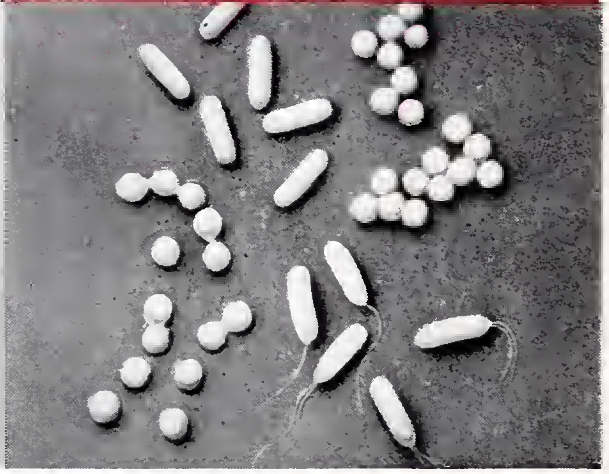

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Alaska Medicine

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THE MANAGEMENT OF THERMAL BURNS

*WILLIAM T. FITTS, JR., F.A.C.S.**

Presented at the Lederle Symposium
Anchorage, Alaska, February 23, 1963.

From the Department of Surgery and the Harrison Department of Surgical Research,
Schools of Medicine, University of Pennsylvania, and the Hospital of the University of Pennsylvania

Burns are a major health problem in the United States. About two million persons are burned each year, and 70,000 of these are hospitalized. The mortality is about 10% for the hospital patient, or 5 for every 500,000 population. Although the preceding figures are impressive, they give little indication of the total medical effort spent in the care of the burned patient. Few, if any, diseases require the sustained and exacting effort required for optimal treatment of a severely burned patient. The long average period of hospitalization is reflected by the fact that about 6,000 hospital beds are always occupied by patients with burns. The burn problem has been intensified by the advent of the atomic age, and some authorities have estimated that roughly 60% casualties due to the bomb will be burn casualties.

Advances in the treatment of burns during the last 25 years, although highly effective in the control of shock, have reduced the mortality of hospitalized patients by only approximately 5%. Table I, taken from a study of the Massachusetts General Hospital data by Barnes[1], compares the burn mortality of hospitalized patients for the years 1939-43 on the one hand, and 1948-1954 on the other. It is noted that improvements in treatment resolved the issue between life and death in only one patient out of twenty. Mortality figures alone, however, do not accurately reflect all the progress which has been made. Many burned patients now survive the hazards which were formerly fatal during the first few days—chiefly shock, only to die in weeks or months from other complications—chiefly infection. Phillips and Cope[2], also studying experience at Massachusetts General Hospital, found that "the survival time for fatal burns was increased by modern therapy from 4.6 days in the 1939 to 1947 period to 15.7 days in 1948 to 1957."

TABLE I
IMPROVEMENT IN BURN MORTALITY

Year	Mortality
1939-1943	15.6%
1948-1954	10.4%

IMPROVEMENTS IN TREATMENT HAVE ALTERED THE ISSUE BETWEEN LIFE AND DEATH IN ONLY ONE OUT OF TWENTY, BUT SURVIVAL TIME OF THOSE DYING HAS BEEN SIGNIFICANTLY LENGTHENED.

Death from burns is greatly influenced by the percentage of body surface burned and by age. Table II, taken from Moyer[3], is illustrative. One half of the patients over sixty died from only a 15% burn, whereas it required a 50% burn to kill half below this age. Blocker et al[4] found 30% involvement of body surface to be the critical level. Below 30% the mortality was low; above it, high, especially in those over 50 years of age.

TABLE II
AGE AND BURN MORTALITY

% Burned	Mortality	
	Age 21-60	Age 61-85
5	0	5
10	0	10
15	1	54
20	2	92
30	10	98
40	30	99
50	54	100
60	78	100
70	93	100
80	99	100
90	100	100
100	100	100

Initial Evaluation of the Burned Patient

The burned patient should be evaluated as an injured patient, and just as any injured patient should be. The burn should not be examined first. Burns may kill early from respiratory obstruction, respiratory tract burn, shock, renal failure, intestinal hemorrhage, and possibly some as yet

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* Professor of Surgery, University of Pennsylvania School of Medicine and Graduate School of Medicine; Associate Chief, Department of General Surgery, Hospital of the University of Pennsylvania.

TABLE III
INITIAL EVALUATION

1. Respiratory - Airway Tracheostomy?
2. Cardiovascular
3. Urinary
4. Nervous
5. Intestinal
6. Integumentary

undeterminted toxic factor. Also, the burned patient may die in the early period from some associated injury or disease, unrecognized because all attention is turned to the burn wound.

The physician in charge should first determine the adequacy of the airway and estimate the presence and extent of respiratory burn (Table III). Phillips and Cope[5] found respiratory tract damage, with or without infection, responsible for 42% of deaths from burns. If considerable edema exists about the face or neck, or if the burns in this area are deep ones, immediate tracheostomy should be performed. The appearance of the tracheal mucosa at the time of tracheostomy may give some indication of the degree of respiratory burn, as may evidence of singeing of the nasal hairs, and redness and edema of the pharynx and larynx.

Second in priority is an evaluation of the patient's cardiovascular system. If shock is present or impending, an immediate intravenous infusion is started, following "cut down" and insertion of a long plastic catheter that accepts a #16 and #18 gauge needle. Upper extremity veins are preferable, if feasible, because the complications of thromboembolism are less likely to follow their use. Blood is sent to the laboratory for appropriate tests, including cross matching, hemoglobin, hematocrit, and B.U.N.

If the injury is severe enough to require intravenous fluids for treatment, or if there is any suspicion of a urinary tract injury, a catheter is inserted into the urinary bladder and left indwelling. The appearance of the urine, and the rate of its excretion gives valuable information as to the severity of the injury and the effectiveness of treatment.

The fourth step is an evaluation of the patient's mental state, an important aid not only in determining whether there may be a concomitant head injury, but also as a guide to the volume of intravenous fluids needed. Restlessness, irritability, and disorientation indicate a severe burn, and call for an increased volume of fluids.

Fifthly, the examiner should check the abdomen to determine if intra-abdominal injury is present, and to determine if oral feeding may be effective.

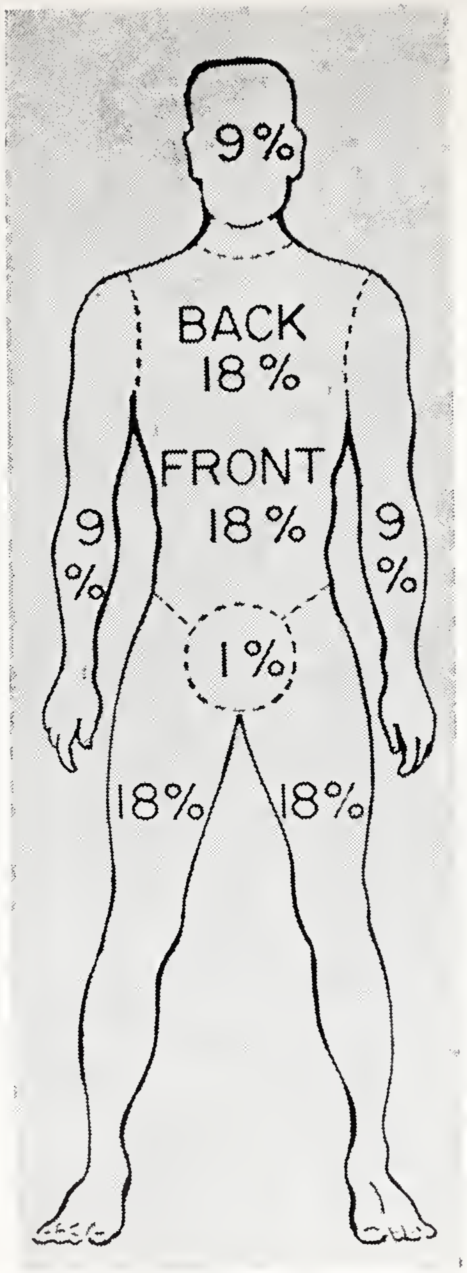
When the examiner has initiated treatment for the above life-endangering complications of a burn or associated injuries, he can then turn his attention to the extent of the burn itself. A quick method of estimating the percentage of body surface burned is by the "rule of nines." (Figure 1). A more accurate estimation is by the Lund and Browder Chart (Figure 2)[6]. It shows the changes in percentage of body surface of various parts that occur during different stages of development from infancy through childhood. The area of the head makes up a relatively large proportion of the total skin area of infants as compared with adults. This disproportion is counterbalanced in infants by the smaller proportionate area of the thighs and legs. The proportion of skin of all other parts of the body is essentially the same for all ages.

An attempt is also made to classify the burn by depth of skin damage, although this may be impossible to do initially. Helpful criteria for estimating depth are given in Table IV, taken from Artz and Green.[7]

The next step in the evaluation is a more complete history. It must include the patient's age, weight, state of health before the injury, drug therapy, tetanus immunization, any known sensitivities, and the time, place and method of injury.

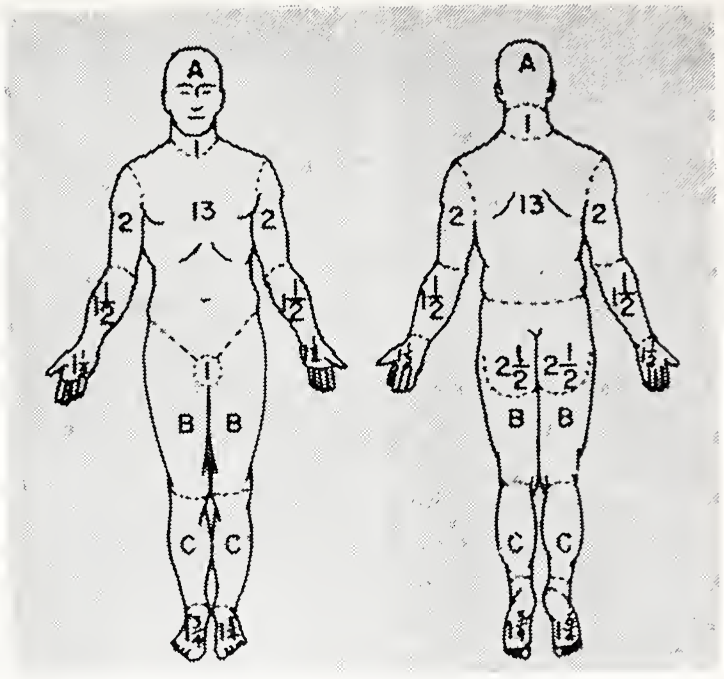
Once the examiner has finished with the preceding evaluation he can decide if the patient should be treated in the hospital or on an out-patient basis. Burns that are of a partial thickness and involve less than 10% of the body surface may be treated on an out-patient basis except in elderly patients or those in poor general health. Such a burn is gently cleansed, using aseptic technique, and a compression dressing applied over a fine-mesh dressing lightly impregnated with an innocuous bland ointment.

For more severe burns or for lesser burns in poor risk patients, plans are made for hospitalization. If the patient has been actively immunized against tetanus, a booster injection is given. If not immunized, he is given 5,000 units of tetanus antitoxin, assuming sensitivity tests are negative. If he is not sensitive to penicillin, procaine penicillin should be ordered, 1,200,000 units b.i.d.



Rule of nines, showing relative distribution of total body surface area.

Figure 1



Relative Percentage of Areas Affected by Growth

	Age in Years					
Age	0	1	5	10	15	ADULT
A—½ of head	9½	8½	6½	5½	4½	3½
B—½ of one thigh	2¾	3¼	4	4¼	4½	4¾
C—½ of one leg	2½	2½	2¾	3	3¼	3½

Total Percent Burned............2° +............3° =............

Figure 2

TABLE IV
CHARACTERISTICS OF VARIOUS DEPTHS OF BURNS

Classification of Depth		Depth Involved	Appearance	Pain Sensation	Wound Prognosis*
First Degree		Stratum corium, stratum germinativum intact	Erythematous, no blisters, dry	Painful; hyperesthetic	Healing in 3 to 6 days, no scarring
Second Degree	Superficial	Stratum corium; parts of stratum germinativum intact	Blisters with reddened base, moist	Painful; hyperesthetic	Healing in 10 to 14 days, no scarring
	Deep dermal	Deep corium, remnants of epidermal appendages intact	Blisters with blanched base, moist	Painful; hyperesthetic; anesthetic in places	Healing in 25 to 35 days, slight scarring
Third Degree	Full-thickness skin	Full-thickness skin down to subcutaneous fat	Leathery, pearly-white or charred, dry	Little pain, anesthetic	Eschar sloughs in 2 to 3 weeks, grafting necessary
	Subdermal	Subcutaneous tissue, muscle, bone	Hard, sunken, charred, dry	Little pain, anesthetic	Debridement and grafting necessary

* If no infections or other complications supervene.

The Treatment of Burn Shock

Great progress has been made in the treatment of burn shock and, if patients are treated early, the large majority of severely burned patients can now survive this phase of their injury. Unfortunately, many die later from other complications, especially infections and respiratory tract injury. This does not, however, minimize the need for optimal fluid therapy, no matter how severe the burn.

Edema is an inevitable sequel of burning. Vasodilation and increased capillary permeability are two fundamental factors involved in its production. In a first degree burn vasodilatation is the only change that occurs. Protein losses are insignificant, and edema is barely perceptible. In second degree burns a large amount of fluid can accumulate beneath the surface of the wound before any visible swelling occurs. Leakage of proteins is observed in areas that receive the most heat. In third degree burns capillaries are thrombosed in and around the wound. This has a twofold effect: erythrocytes are removed from the circulation, producing anemia, and fluid exchange ceases. In general, red blood cell destruction is a significant problem only in connection with deep burns. Red cells are trapped in the burned area at the time of injury and are hemolyzed there. From a clinical standpoint it is wise to assume that in a severe burn the erythrocyte destruction is approximately 10 to 15% of the total red blood cell mass in the first 48 hours.

Fluid losses are incurred most rapidly early after burning. The rate of edema formation then declines and finally ceases about 48 hours after burning, at which time edema is maximal.

Several formulas have been proposed as guides for the administration of fluid in the shock period. Evans' formula[8] has been widely used. Evans determined the quantity of colloid to be given during the first 4 hour period by multiplying the patient's weight in kilograms by the percent of body surface involved with second or third degree burns. To illustrate, a 70 kilogram man with a 30% burn would be given 2,100 ml. of colloid (blood, plasma, or plasma expander) in the first 24 hours. An amount of istonic salt solution equal to that of colloid is given and in addition 2,000 ml. of 5% glucose in water are added to ensure a good urinary output. One half of the fluid requirements for the first 24 hours should be concentrated in the first eight hours. For the second 24 hour period only one half the previous volume of colloid and salt solution is given, with 2,000 ml. of glucose in water.

Recent studies [9,10,11] suggest the efficacy of a formula with more electrolytes and less colloids than the Evans' formula. The formula recommended by the Committee on Trauma of the American College of Surgeons is the Brooke Army

TABLE V
BROOKE ARMY HOSPITAL FORMULA

Wtg. in Kgm. × % Burn × 0.5 cc. = Colloid
(Plasma, Blood or Dextran)
Wtg. in Kgm. × % Burn × 1.5 cc. = Electrolyte
(Lactated Ringers) or (2:1 P.S.S. and 1/6 molar lactate)
Water Requirement (Adult) = 2000 cc.
(5% dextrose in water)

(Burns over 50% body surface calculated as 50% burns)

Hospital Formula (Table V). In this formula only half as much colloid is given as in the Evans' formula, but one and one half times more electrolyte solution. An example of the use of the Brooke formula for a 70 kilogram patient with a 30% burn is as follows: Colloid = 70 × 30 × 0.5 = 1050 ml. Electrolyte solution = 70 × 30 × 1.5 = 3150 ml., and 5% glucose in water = 2000 ml., giving a total of 6,200 ml. of fluid during the first 24 hours. Burns of more than 50% surface area are treated by the formula as a 50% burn.

One is tempted to give sodium chloride in 0.9 per cent solution (physiologic or normal saline) as the electrolyte of choice, since it is inexpensive and available. It is not the ideal replacement solution, however, since it contains an excessively high concentration of chloride and may produce hyperchloremic acidosis in large doses. A better balanced solution may be obtained by mixing 2 volumes of 0.9% saline solution and one volume of sixth-molar lactate solution. In addition there are prepared solutions on the market of a balanced nature, e.g. lactated Ringer's solution. The experiences of Markley and co-workers [9,11] show good results with the use of physiological saline alone, and the advantages of a more balanced solution may be more theoretical than practical. It is helpful to know that under disaster conditions physiological saline could be expected to give good results.

A frequent mistake is to give too much fluid when a formula is followed. An overestimate of the burned area is common. Overhydration is particularly apt to occur in patients with more than 40% burns, in children, in patients with respiratory burns, in the elderly, and in those having serious heart disease.

Rigid adherence to a formula is foolhardy and may lead to disaster. A formula is only an outline with which to plan. Fluids must be varied depending on the patient's response to therapy. Several helpful guides are listed in Table VI. The urinary output is useful. An indwelling catheter in the urinary bladder enables one to follow the rate of formation or urine closely and to judge the adequacy of intake. An output of between 20 ml. and 40 ml. per hour is optimal for most patients.

TABLE VI
GUIDES TO TYPE & SPEED OF FLUID THERAPY

**Foolhardy to Use Formula Except as an Outline:
Vary Formula Depending On—**

1. Vital Signs
   Decreased B.P. and/or rising pulse:
   Increase Colloid
2. Mental State
   Restlessness
   Irritability   Increase volume
   Disorientation
3. Hematocrit—50% is optimum
4. Urinary Output 20 cc. to 40 cc. / hour is optimum
5. Weight—should gain first 48 hours, then lose.

Fluid intake must not be gauged by urine output alone. The vital signs are also valuable. Decreasing blood pressure and/or a rising pulse rate are indications for increase in colloids. Restlessness, irritability and disorientation usually indicate a need for more fluid.

The rapidity with which plasma is lost from the burn surface and into the tissue beneath and about the burn has long been recognized and, until recent years, plasma alone has been considered the proper colloid with which to combat this loss. Some whole blood is also needed in burn therapy. The red blood cell mass in the average burn patient decreases about 45% from burn to first grafting and 185% from burn to discharge[12]. Whole blood is needed not only to prevent anemia, which is known to occur several days after burning. Unfortunately, the determination of hemoglobin and hematocrit level is not a completely reliable guide for the volume of whole blood needed. Artz[13] states that "In general, patients with a total burn of 20 to 40% will require blood in amounts equal to 20% of their pre-burn blood volume during the first 48 hours; patients with a greater than 40% total burn will require blood equal to 20% of their pre-burn blood volume in the first 12 hours and an equal amount during the next 36 hours." Blood is rarely required in treating burns of less than 15 or 20% of body surface. Use of the hematocrit level may be helpful, along with other signs, in adjusting the rate of fluid injection. A rising hematocrit during the course of treatment suggests the need for increasing the rate of injection of saline solution and/or plasma.

The Treatment of the Burn Wound

Probably few lesions have been treated with more harmful agents than the burn wound. Many examples (e.g. tannic acid) can be given of the use of agents applied locally which were toxic and delayed healing. Many substances that have been advocated for local use have, after careful study, proved to be of no value. Of first importance in the treatment of the burn wound is the rule of "Primum Non Nocere."

Enzymatic debriding agents have been advocated by several investigators, but in spite of impressive laboratory results, they have not proved to be very effective in man. The best method of cleaning the burned area, if this is necessary, is still by washing with surgical soap and sterile water or physiological saline solution. The best debridement is still achieved by time or the surgeon's scalpel, and the best dressing is still a fine mesh gauze lightly impregnated with an innocuous bland ointment.

Clinical studies have shown that in third degree burns rapid healing is best obtained if the granulating surface and surrounding skin are kept meticulously clean with soap and water plus the frugal use of ether or benzine for the removal of keratin scales and lacerated tissues. Skin grafting is faster than any known therapeutic agent in providing coverage for areas of deep burns, reducing the bacterial flora of a wound, and restoring the critically burned patient to good health.

One of the most striking changes in burn therapy in recent years has been the more frequent acceptance of the exposure method of treatment[4,14]. The exposure method is not a treatment of neglect but a method which requires skill and thorough knowledge of the principles of wound healing. An abuse of the exposure method has been the prolonged exposure of full thickness burns during the sloughing stage. As soon as a third degree eschar begins to loosen, the exposure method must be terminated and removal of the eschar hastened by every possible means in preparation for early skin coverage. Granulating surfaces should never be exposed. Exposure is contraindicated in patients treated on an out-patient basis. Encircling burns of the body or extremities are frequently difficult to expose adequately, and are usually better treated by the occlusive dressing method. However, occlusive dressings and the exposure treatment are not mutually exclusive; they should be used to supplement each other. Burns of the head and neck and of the perineum are probably best treated by exposure.

Occlusive dressings are required for the majority of burned areas. Such a dressing should absorb the fluid and keep the wound surface dry and thereby free from the growth of bacteria. It should be applied with even, resilient compression in such a way as to eliminate dead space and to produce a splinting effect. The material placed next to the wound must not macerate the tissue or damage the remaining viable epithelium. Dry, fine mesh gauze, lightly impregnated with petrolatum, is satisfactory. The initial dressing can frequently be left in place for seven to nine days. Thereafter, dressings should be changed about every five days.

General agreement exists that full thickness burns should be excised and the defect grafted as soon as "feasible." Early excision and grafting shorten the period of protein loss from burn surfaces, diminish infection and toxic absorption, and reduce scar formation. Immediate excision and grafting, however, may be precluded by two factors: 1. The general condition of the patient, which may make additional trauma too hazardous, and 2. The difficulty of immediately judging the depth of the burn. In burns of very limited extent that are obviously full thickness, excision and grafting can be done immediately. In extensive burns the additional trauma of anesthesia and operation may be lethal during the early stages. Because grafted skin is inferior to superficially burned skin that has regenerated, the ultimate result in questionable cases is better if time is given for demarcation before skin is excised. Needless delay, however, invites the formation of scar tissue with all its subsequent disadvantages, and also prolongs the general debility of the burned patient. It is then a question of balance, and obvious full thickness burns should be excised and grafted as soon as the patient can withstand the operation. If the normal skin of the patient is insufficient or if the added trauma of taking the graft is felt to be unwarranted, homografts can be used.

The early hope that corticotropin and cortisone might effect a permanent "take" of homografts has been shown to be ill-founded. In extensive burns, especially in children, the temporary covering of the open wound with homografts may be life saving, even through subsequent replacement with the patient's own skin is necessary[15,16]. It is obvious that important needs are the development of a method for preserving homografts for long periods of time, and for making their "take" permanent.

Recently treatment of burns with ice water, or cold water, has been revived[17,18]. Such treatment is said to relieve pain, decrease the incidence of infection, and decrease the loss of fluids. Wilson et al[10] state that from their results in experimental work on burns in pigs, cold water appears to be an effective method of treating such burns. The author believes that this method should still be considered experimental.

Problems of Infection

In spite of the development of many potent antibiotics, sepsis continues to plague the severely burned patient. It is probable that infection seems more of a problem now than it previously did, because more severely burned patients now survive the early post-burn phase. Many die of respiratory infection, especially following a respiratory burn. In addition, septicemia and death from gram negative organisms, especially Pseudomonas aeruginosa have become prevalent. Tumbusch et al[20] found that, while survival from staphlycoccal and a number of other types of septicemia had been attained, Pseudomonas septicemia had always been fatal. They found an early sign of blood stream invasion with Pseudomonas to be small areas of focal necrosis of granulation tissue. Even though large doses of Polymyxin B and/or colistin sulfate were given the clinical course was not altered, and death ensued.

Infection may play an even more significant role in burn mortality in the event of an atomic war. Brooks et al[21] found a great increase in experimental burn mortality if external body irradiation were added.

Nutrition

Apart from the specific treatment of the burn wound and its immediate complications, intensive support of nutrition is indispensible. Maintenance of good nutrition is at times impossible in extensive burns, and remains one of the unsolved problems. Frequent blood transfusion and nutritional adjuncts given intravenously or orally have aided, but maintenance of good nutrition is often impossible. The best means of providing adequate calories is by mouth and this method should always be used if possible.

Fractures and Burns

Fractures associated with contiguous burns will probably occur in large numbers in the event of an atomic war. At present no good method has been reported for treating this combined injury. The ideal method is one which is optimal for treating the fracture and which allows complete freedom for treating the burn. Experiences with treating fracture-burn problems by plaster casts have been disastrous in some instances, and skeletal traction may not be feasible.

The author and colleagues of the Harrison Department of Surgical Research of the University of Pennsylvania have been interested in studying the fixation of fractures associated with burns by means of intramedullary nails[23]. It is popular to speak with horror and to label as sinful the use of "hardware" to fix open fractures. The insertion of a foreign body under such circumstances is believed to add greatly to the risk of infection. We readily admit that internal fixation in these instances is certainly not ideal treatment. Ideally, the fragments would be held by moral suasion, as the late Clay Ray Murray said. But since this can't be done, the advantages of the rigid fixation that is afforded under certain circumstances by internal fixation, especially with intramedullary nailing, may outweigh the risk of insertion of the nail. We believe that intramedullary nailing for some fractures associated with contiguous burns may be the best method in the handling of mass casualties, especially if other methods, such as skeletal traction for fractures of the shaft of the femur are not feasible. The danger of operating through a burned area has not proved to be great in our experiments on dogs. Peltier's experience[23] has been similar if the operation is carried out reasonably soon after burning. Our studies indicate that rigid immobilization of contaminated bone is of importance in the prevention of bone and soft tissue infection. If rigid immobilization necessitates open reduction and internal fixation, the risk of infection from operation and use of the foreign body, even through burned skin, may be less than the risk of using closed methods which do not fix the fracture securely and which preclude the best method for treatment of the burn. A great advantage of intramedullary nailing over skeletal traction is that it allows freedom in moving the patient, and, therefore, would allow early evacuation of military casualties.

Prevention of Burns

The physicians' responsibility in the management of burns does not end with treatment. He is in an unusual position to determine the cause of burns, and to give valuable advice for preventing burns. It is thought that at least half of all burn accidents could be prevented. Open fires and unprotected heating units are responsible for an unusually large number. Ignition of clothing is a frequent mode of burning, particularly in young girls, whose skirts are readily kindled by contact with fire. Block's[24] analysis of 344 burned children revealed that ignition of clothing caused the burn in 46 per cent. The home, rather than the place of employment, is the place where burns are most likely to occur. In Colebrook's series[25], as well as in Moyer's[26], 70 per cent of all burn accidents occurred around the home. Moyer[27] has shown that the incidence of burns should be greatly decreased by abolishing the unguarded open flame, by dressing girl children in pants, and by prohibiting the manufacture of garments from flammable fabrics.

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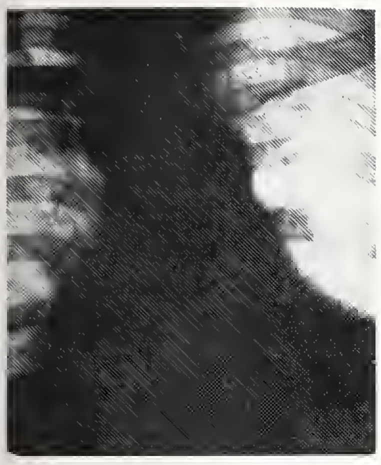
MYXEDEMA HEART DISEASE

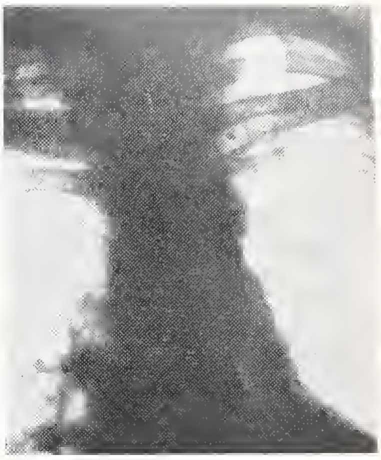
REPORT OF A CASE

HENRY WILDE, M.D.
JUNEAU, ALASKA



Before Thyroid Therapy

The busy practitioner is often tempted to treat cases of congestive heart failure in older individuals symptomatically with the use of cardiac glycosides and diuretics without considering the rare causes of heart failures; some of which are remedial with specific therapy. It is therefore worthwhile to recall that not every case of heart failure is due to arteriosclerosis, hypertension or rheumatic valvular disease. It is the purpose of this report to present the history of an elderly woman who was referred to the author for treatment of intractable heart failure.



After Thyroid Therapy

CASE REPORT*

The 62 year old part-negro widow was first seen on 11-5-58 complaining of severe exertional dyspnea, moderate orthopnea, dry skin, swelling of face and legs without dimpling, poor hearing, marked cold intolerance, loss of energy and frequent grand mal epileptic seizures. Physical examination revealed an apathetic woman volunteering few subjective complaints. Facial characteristics showed the typical changes of advanced myxedema though these were slightly obscured by the negroid racial characteristics.

There was doughy swelling of the skin and only very slight dimpling could be obtained at the ankles. The thyroid gland was not palpable. Blood pressure was 110/75, pulse 60 and regular. The speech was husky and slow. There was no neck vein distension and no paradoxical pulse. Lungs were clear and heart sounds were distant without palpable apical pulse. The liver and spleen could not be felt and there was a well functioning transverse colostomy. Deep tendon reflexes were sluggish and revealed slow return. The arm to tongue circulation time was 24 seconds and a venous pressure was 64 mm of water.

Laboratory studies included a normal hemogram and urinalysis, a serum cholesterol of 680 mg, a BMR of minus 50 and a PBI of 1.7 microgm. An electrocardiogram revealed a sinus rhythm, T-wave inversion of precordial leads and low voltage extremity leads compatible with myxedema. A chest film revealed a large globular heart shadow which was thought to represent cardiac dilatation or pericardial effusion (see figure). The patient was placed on thyroid 60 mg once daily, was kept on a salt free diet, Dilantin was given as an anticonvulsant and digitoxin 0.1 mg daily was continued.

Two days after initiating thyroid therapy extreme orthopnea and a drop in blood pressure to 80/65 appeared. Neck veins became distended but no chest pain developed. Three attempts at pericardial aspiration were made but no effusion was found. A 500 cc phlebotomy was then performed, the patient was given 1.0 mg of Digoxin intravenously and thyroid was reduced to 15 mg once daily. Within one week there was marked improvement and the patient diuresed 12 lbs. Gradually increasing amounts of thyroid up to 120 mg daily were tolerated without any further evidence of circulatory failure or angina. A later increase of thyroid to 150 mg however resulted in mild symptoms of thyrotoxicosis.

Two months later there was a marked decrease in heart size (see figure), the serum cholesterol was 210 mg, the BMR minus 5 and a PBI was 3.8 microgm. The patient resumed her work as a housekeeper within three months. There have been no further major cardiovascular symtoms in the subsequent four years and she recovered without complications from a compression fracture of the dorsal spine and later from a radical mastoidectomy. She is being maintained on thyroid 120 mg daily and is still working full time at the age of 67. An attempt to withhold Dilantin last year failed due to recurrence of grand mal epilepsy.

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* From the Department of Medicine, St. Ann's Hospital and Juneau Clinic, Juneau, Alaska.

DISCUSSION

The clinical features of myxedema heart disease consist of severe hypothyroidism associated with a diffusely enlarged heart, slow indolent contractions and low complexes on the electrocardiogram. Exertional dyspnea, cardiac arrythmias, pleural effusion, ascites, coma, psychosis or convulsive disorders may likewise be present.[1-5] All features should be reversible with thyroid therapy. It is generally recognized that myxedema heart disease develops only in severe hypothyroidism with basal metabolic rates of less than -25. It is thought to occur only if skin changes of myxedema are present and may develop in as many as 70-80% of such patients. Fully evolved cases, such as the one presented here, are nevertheless rare today.

The pathophysiologic changes in myxedema heart disease are characterized by a reduced oxygen consumption of all tissues, reduced heat production, reduced peripheral blood flow out of proportion to lowered oxygen need, and increased peripheral vascular resistance. The arteriovenous oxygen difference is increased due to a slower circulation time through the skin with relatively more efficent oxygen extraction by the tissues.[6] The cause of the bradycardia which one associates with hypothyroidism remains unexplained. The arm to tongue circulation time is usually increased but venous pressure may be normal unless marked congestive failure is also present. The circulation time was elevated in our patient and a venous pressure was normal until thyroid therapy was started and acute left ventricular failure supervened. Determination of the venous pressure and circulation time may therefore be helpful in evaluating a patient with marked cardiomegaly who is also suffering from hypothyroidism.[3]

There is still some disagreement about the cause of cardiomegaly in myxedema heart disease and it is likely that both pericardial effusion and diffuse edema of the myocardium with resultant cardiac dilatation may occur. A pericardial effusion was thought to have been absent in our case. In a few autopsied patients a homogenous hematoxylin blue infiltration was seen throughout the myocardium with associated necrosis and replacement of muscle fibres by connective tissue.[2] Evidence that hypothyroidism predisposes the patient to early and severe arteriosclerosis is being questioned in recent reviews.[7] Some authors feel that myxedema heart disease is rarely the cause of heart failure and that hemodynamic changes seen in patients with severe hypothyroidism are an adaptation to the lowered metabolic requirements of all tissues.[8] The serum cholesterol is markedly elevated in most but not all reported cases of myxedema heart disease and should revert to near normal levels after adequate replacement therapy.

Our case illustrates rather dramatically that initial treatment should be cautious and should commence with very small amounts of thyroid which is increased slowly over a period of several weeks. Patients suspected of suffering from coronary artery disease associated with the syndrome of myxedema heart disease may do better when maintained in a less than euthyroid state. The dramatic circulatory collapse exhibited by our patient after two days of thyroid therapy with 60 mg daily is thought to have been due to the increased peripheral oxygen demand at a time when myocardial recovery was not yet sufficient to supply peripheral needs. Most gratifying results can be achieved if the clinician recognizes this disease early, treats it cautiously and follows the case diligently. Failure to recognize myxedema as the cause of cardiomegaly will invariably result in early death.

SUMMARY

A case of myxedema heart disease is presented. Treatment with 60 mg of dessicated thyroid resulted in dramatic circulatory collapse. Resumption of therapy with 15 mg of thyroid and graduate increase of thyroid to 120 mg daily was followed by complete recovery of the patient.

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CONGENITAL ABNORMALITIES OF A NEWBORN

REPORT OF A CASE OR AN EXCELLENT DELIVERY WITH A DISAPPOINTING RESULT

MARSHALL A. SIMPSON, M.D.

EAGLE RIVER, ALASKA

Part I

J.B. delivered an apparently normal male child, breech first, after a short period of labor; but the child died quickly in spite of the best efforts to resuscitate it. This is why, and it is always saddening when it happens, but especially so in this case, as explained in Part II.

The infant was born at 1:09 p.m. after an unusually normal delivery, but he just did not cry. Respirations were practically nil in spite of mild stimulation. The cord was not occluded. There were no gross defects, but still the child just did not respond. A pediatrician was called to care for the infant while the delivering physician cared for the mother. Though a heart beat was occasionally detected the baby still was not responding. The baby expired at 2:15 p.m. Only distended jugular veins and an enlarged liver had been noted.

The findings at post mortem revealed these problems:

The heart was in the midline, was enlarged and showed multiple congenital abnormalities. Both the pulmonary artery and the aorta came off the right ventricle. The aorta was a small vessel partially stenotic at its opening but still patent, and supplied only the neck and head structures. A small communicating vessel connected the aorta to a very large dilated pulmonary trunk, and the pulmonary vessel served as the arch of the aorta. The right ventricle was, of course, hypertrophied. There was a large septal defect noted between the right and left atria involving the superior portion of the ventricle. I don't know that this is a specific type of congenital heart disease, it being somewhat closely aligned to a tetralogy of Fallot.

The liver was large, congested, but otherwise unremarkable.

As soon as the thoracic organs had been removed, the anterior fontanelle of the head collapsed precipitously. Whereas at the beginning of autopsy the fontanelle had been examined and appeared to be normal, it was depressed a full inch on completion of the abdominal and thoracic examinations.

Dr. Simpson

The scalp was incised and reflected in the usual manner. The skull bones were well formed, more calcified than usual, less malleable and pliable than usual; and along the suture lines are definite areas of hemorrhage where molding had caused injury.

The calvarium was opened in the usual manner and a tremendous hydrocephalus was immediately obvious. Actually, the spinal cord, the medulla, and the cerebellum appeared to be normal, but all the supra-tentorial structures were completely abnormal, consisting of a small nub of tissue in the region of the pons, the lower half of the pons being normal, and above this point normal structures being absent. Arising at this point was a large thin-walled sac, paper thin, serving as the cerebral cortex, collapsing into a membrane less than an inch in diameter when the fluid was completely removed. I suppose one way of explaining this would be that the hydrocephalus developed in this child at the time of his early development, so that the cerebral hemispheres fused to form one single thin-walled sac which expanded with age.

Part II

J.B. was first seen in November 1961 when a routine O.B. history and physical were done. Except for some erosion of the cervix her health was perfect. Not only that, but she was a most cooperative young lady, and she wanted to have her first child in the easiest way possible. Her doctor wanted to help her have that experience because it was during the time J.B. was pregnant that he was learning the proper technic for making this possible.

Prenatal visits were unremarkable, except for gaining a total of twenty-nine pounds of weight and showing a slight trace of sugar on the last two visits.

Beginning in February J.B. was taught what to do and expect at the time her child was to be born. She followed suggestions and instructions to the "T." The doctor was very impressed as this would prove to be the first time he used this method with success. On almost every prenatal visit a few moments were taken to show J.B. what to do at the time of delivery.

On June 22 J.B. noted uterine contractions beginning about 4 a.m. By 7 a.m. she was in the office in active labor and a routine check showed all well with 4-5 cm. dilation of the cervix, but the breech was presenting. J.B. was instructed in what to do and how to relax and then she went straight to the hospital. Pelvimetry showed an adequate pelvis and apparently normal fetus. As labor progressed J.B. was given the usual perineal prep. Neither she nor the baby showed signs of distress.

About 12:30 p.m. labor was progressing faster and dilatation was about complete. During this time no sedation was requested nor offered.

In the delivery room the usual routine was followed, except no anesthetic was required or given. Drapes were applied after perineal wash. The episiotomy was done at the proper time, slowly with care. After the buttocks presented through the vaginal outlet the infant was easily delivered. The mother had **no pain** and was entirely cooperative throughout the whole procedure. There was positively no drug effect on the infant. There was a minimum amount of bleeding. No oxytocics were required. The episiotomy was repaired with ease and complete cooperation from the patient.

To the physician it was a truly remarkable thing to see the relaxed attitude of the mother through the whole procedure, even though she had no anesthetic nor analgesic whatsoever.

But what a disappointment to expect a perfectly normal healthy infant delivered in an ideal manner, the first time the physician used this particular method, and to find the infant just doesn't breathe despite all efforts. It is depressing and shocking for physician as well as the parents. Such an abnormality would probably never happen again in the physician's experience. Why did it happen at this time? Such an excellent delivery! Such a disappointing result!

Summary

This case presents a mother comfortably delivering her first child breech over a mid-line episiotomy without the use of analgesic or anesthetic, but using only the art of suggestion, or hypnosis. Though no depressants were used whatsoever, the apparently normal child failed to respire in the normal manner and died about one hour after birth. The cause of death was multiple congenital abnormalities including congenital heart and brain diseases.

Follow-up

Though childless the mother, six months later, remembers the process of birth as a pleasant experience, not associated with fear or discomfort, as she thought she might have found it before she consulted her physician. I believe she is still a little apprehensive about giving birth to another child with congenital deformities but she has been reassured that the possibility of this happening is extremely remote. I would find it a great privilege to assist again this beautiful young lady in the process of childbirth and to see her give birth to a perfectly normal child in the easy manner to which she is now accustomed.

PHYSICAL THERAPY AND EVERY DOCTOR

BETTY KESTER, R.P.T.
ANCHORAGE, ALASKA

How can physical therapy help you, the Alaskan doctor? By helping you to help your patients.

Physical therapy is, fundamentally, forms of heat, massage and exercise prescribed by a doctor and administered by a registered physical therapist. The word "registered" is the key to the fact the therapist has attended a school approved by the American Medical Association and he, or she, has been trained to use all modalities to the patient's best advantage. Originally physical therapy was used after a cast had been removed in fracture and paralysis cases, therefore it was mentally associated with orthopedists. This concept has been changed through the years until now there are very few doctors who cannot benefit by utilizing the services of a physical therapist. The general practitioner, surgeon, psychiatrist, internist, pediatrician, neurologist, obstetrician, otolaryngologist, and orthopedist are all finding therapeutic and preventative uses for physical therapy.

Often patients come in complaining of backache, or neck and headache. If there are no organic reasons, perhaps you remind them that better posture might help, or mild exercise. The patient goes home and does nothing because he does not know what to do. Patients need to be taught, and a physical therapist is a teacher.

The heart patient can be encouraged to keep better muscle tone and circulation and to be more comfortable through mild exercise. The cerebral hemorrhage patient can be helped to keep the normal range of motion in his affected arm and leg, to regain coordination if the muscle function returns, and to ambulate. In these long-term infirmities, the family can be taught what to do by the therapist.

A great many neurological cases, ranging from multiple sclerosis to disc surgery, are given physical therapy. Forms of heat for comfort, muscle re-education and gait training are the usual requirements. Then, too, the facial diseases involving the cranial nerves, such as Bells palsy and tic douloureux, respond more quickly when given heat, massage, exercise and galvanic current stimulation, along with the proper medications. The personal encouragement of the therapist is also a definite aid in any long-term trauma or disease.

Betty Kester with Equipment

Pregnant women are often referred, individually, or in classes, for relaxation exercises and general prenatal exercises. In addition to preparing the muscles and breathing for better cooperation during the period of labor, many backaches can be avoided through proper posture during pregnancy. Post natal patients thank their doctors for insisting upon their doing proper exercises immediately. Without help, they are apt to maintain a relaxed posture for lack of muscle tone and proper exercise.

The advantages offered by physical therapy have long been recognized in the treatment of children for congenital deformities, asthmatic cases, burns and postural defects. More and more doctors are applying the same principles in the treatment of their adult patients. With children, as well as with adults, teaching them proper exercises to be done regularly at home suffices. Regular checkup visits to the therapist, over a period of time, is all that is required thereafter to keep the patient interested and to remind him to do his exercises.

Many surgeons use physical therapy before and after surgery. When a muscle is going to be weakened by surgery or by immobility directly following surgery, the muscle is often built up ahead of time through resistive exercises. However, most often the therapist is called upon to help the patient regain range of motion after surgery near a joint; to help master better breathing after chest surgery; to help gain more strength after any surgical procedure. Keeping the proper range of motion and good skin health, after amputations, can readily be relegated to the therapist by the busy surgeon. Proper use of prosthetics is another item in which the therapist specializes.

You may be thinking, "Who pays for all this? My patients are already complaining about the expense." Through records kept in physical therapy departments throughout the Northwest, it has been found that approximately 80% of the patients are covered by insurance. Insurance companies do not object to normal physical therapy charges because they know a well-trained therapist can accelerate patients' recoveries. In referrals for a reasonable amount of therapy even privately paying patients seldom object.

In one case a boy was lying in bed, flat on his back, fearful of moving because a neurological disease had made his muscles weak and painful. The doctor sent a private physical therapist into the home Through encouragement and exercise, the boy was soon moving freely about the bed, had come out of his depression, and was looking forward to using crutches. Within a few weeks, he was able to go out and his parents took him to the Crippled Chidren's Treatment Center. There he could receive whirlpool and resistive exercises. It was not long before he was once more back in school, strong and well coordinated, the time of recovery cut very considerably by physical therapy.

A stroke patient was lying helplessly in an expensive hospital bed. The doctor asked the hospital therapist to get the patient ambulatory and as self-sufficient as possible. She used hot packs, massage and exercise of the painful shoulder and hand and started the patient standing. Before long, he was able to walk independently, with one crutch, and to partially care for his daily needs. As a result, he is now able to live with his family at a much lower cost to the welfare department.

A workman injured on the job was not recovering rapidly and the insurance adjuster complained he thought the man a malingerer. The doctor rechecked the patient and found that the workman still had reason for complaints because of tightness in the back and leg muscles. The patient was referred to a physical therapy office for diathermy, massage and exercise. Within two weeks he was back on the job with everyone concerned satisfied.

A young man had a severe back fracture with partial paralysis. Being without funds he turned to the State Rehabilitation program for help. While seeing that he received training for a new vocation, the Rehabilitation office sanctioned the doctor's orders for whirlpool, exercises and crutch walking to alleviate discomfort, to facilitate mobility, and to avoid contractures.

A doctor being confronted with how to care for a traumatic nerve injury turned to the Elk's program. The family lived in an area remote from a medical center and could not afford hospitalization for the long after care. The therapist went into the home, gave a muscle test and taught the family how to apply safely heat and exercise. She periodically went back for follow up treatments.

Our State is new, but it is reasonably well covered by available facilities. The properly trained, registered physical therapist offers his or her ability, knowledge and imagination to meet the requirements of all the doctors for their patients. A written or telephoned prescription from you, the doctor, is all that is necessary.

UNITED STATES PUBLIC HEALTH SERVICE NEWS

ANCHORAGE M.O.C. CONFERENCE

During the week of February 18 through 25, a conference was held in Anchorage under the auspices of the United States Public Health Service for consideration of three major health problems in Alaska:

1) the high infant mortality which is about 68 per 1,000 lives births in contrast to approximately 27 per 1,000 elsewhere in the country.

2) the tremendous number of crippling diseases of childhood especially the diseases of the ear, nose and throat with complications such as meningitis, brain abscess and deafness;

3) the high incidence of tuberculosis which is approximately 300 per 100,000 population in contrast to 35 per 100,000 elsewhere.

Convening for this purpose were Medical Officers in Charge from all of the PHS Alaska Native Health Hospitals, PHS Alaska Native Health Program Consultants, physicians and public health nurses from the Alaska Division of Public Health, private Anchorage physicians, scientists from the Arctic Health Research Center, social workers from the Division of Welfare and the Bureau of Indian Affairs, and representatives of voluntary health organizations such as the Alaska Crippled Children's Association, the National Tuberculosis Association and the Elk's Cerebral Palsy Program.

The group outlined these essential features of a successful program.

1) A joint evaluation of the medical needs of native villages.

2) Establishment of village specialty clinics for Maternal Child Health-Crippled Children's Services, and Tuberculosis.

3) The referral of high risk obstetrical cases to the field hospitals for delivery to the extent that funds permit.

4) The initiation of treatment on all case of untreated tuberculosis—in the Anchorage Hospital for all active cases or in the field for all inactive cases.

5) The improvement of care provided in villages by the Public Health Nurse and the village aides.

6) Health education of village aides and residents of villages.

CHEST SURGERY RESIDENCY PROGRAM APPROVED

The PHS Hospital in Anchorage has recently been approved by the AMA for residency training in chest surgery. The details of the training program have not been announced.

The program should prove to be of real value both to the overall PHS Residency Program and to the thoracic service at the Anchorage Hospital. In the lower 48 States, with the marked reduction in the number of patients requiring pulmonary resection in the management of tuberculosis many of the resident programs are unable to find adequate clinical material in this field.

None of the PHS Hospitals offer a full residency in thoracic surgery at this time, and the residents in General Surgery have had all too little experience in this field. The tuberculosis problem in the western American Indian population and in the Native population of Alaska remains one of the major problems in the Indian Health Program. The overall tuberculosis incidence is probably greater among the North American Indian than it is in Alaska, however, the cases are spread over many states and the tuberculosis control program cannot be as well concentrated as is the program in Alaska.

For several years the thoracic surgery program in Alaska has been pushed in an effort to become current with the list of known tuberculosis patients awaiting surgery. This goal has not yet been achieved, although there is no longer a large back-log. Three or four resections are usually scheduled weekly with a rate of about 120 resections annually, 90% of these cases for tuberculosis. Because of an unusually high incidence of bronchiectatsis among patients, bronchoscopy and bronchography are now routine preoperative studies. As a consequence, there is a very active endoscopy service with approximately 150 bronchoscopies and esophagoscopies per year.

It is hoped that the added stimulus of participation of the PHS Hospital in a residency program will further strengthen the efforts now being brought to bear to control the dissemination of tuberculosis among the Natives of the state. Eradication of tuberculosis will shortly become a proper and realistic goal.

President's Page . . .

Ample time has been arranged at our State Meeting to discuss the "business" of the past year and plan the program for the next year.

The directions to the new officers and the course of action for the next year are primarily originated in the resolutions adopted at this meeting. This collection of considered, and debated, and balloted thinking then becomes the "order of the year" to your new President and his associates.

With this in mind it would be helpful to prepare your resolutions now, so that resolutions adopted by local societies may be exchanged with the other component societies—for mutual premeeting evaluation and consideration. All resolutions should be sent to the Chairman of the Resolutions Committee, Dr. Rodman Wilson, by the first of May.

An annual problem is that of legislation, particularly legislation pertinent to the Medical Practice Act, and new Sessions laws, relating to the practice, administration and supervision of medical practice.

Give thought now to this act, its revision, or the development of a new act. With your ideas, and with recommendations from the committee on the Revision of the Medical Practice Act, we should be prepared to present our thoughts to the legislature at its next meeting.

It has been requested of this legislature and the Judicial Council that present medical legislation be tabled and hearings be held by that body (Legislative Council) throughout the state, or in Juneau, prior to the next meeting of the Legislature. This will enable interested individuals and societies to have an opportunity to present the problems in its entirety and avoid piecemeal legislation.

By the written word of this Act, and by the interpretations of this Act by the State of Alaska, we work and live. It is a method of direct control of all of our professional activities, and influences not only the present members of this profession, but other fields of interest as well—and is a determining factor in the lives of those in medical practice who have not yet come to practice here—but will. For you information House Concurrent Resolution No. 33, as passed by The Judiciary Committee, is reproduced below. This area is certainly worthy of our interest and concern.

The physicians of Alaska join in expressing pleasure at the appointment of Colonel Levi M. Browning as Commissioner of Health and Welfare by Governor Egan on March 15. Dr. Browning will assume his new duties on April 20 upon retirement after serving 26 years in the Army and Air Force medical departments. Since he has served two tours of duty in Alaska, as Commanding Officer of the 5001st Air Force Hospital at Ladd Air Force Base in Fairbanks in 1949-50 and as Commander of the 5040th AFB Hospital at Elmendorf in Anchorage in 1950 and again in 1959-62, we heartily agree with Governor Egan that Dr. Browning has "gained valuable experience and knowledge as to Alaska's health and welfare problems." In addition to his administrative experience in the state, Dr. Browning has long been interested in the medical history of Alaska and has consented to speak on this subject at the Alaska Medical Association convention banquet.

We plan a warm welcome for all of you in May. Don't bother writing—come in person.

WILLIAM J. MILLS, JR., M.D.

March 21, 1963

Referred: Judiciary
Introduced: 3/16/63

IN THE HOUSE BY JUDICIARY COMMITTEE

HOUSE CONCURRENT RESOLUTION NO. 33
IN THE LEGISLATURE OF THE STATE OF ALASKA
THIRD LEGISLATURE—FIRST SESSION

Relating to a review of the laws pertaining to medicine and medical practice.

Be It Resolved by the House of Representatives, The Senate Concurring:

WHEREAS, the laws pertaining to medicine, medical practice and related subjects are both inadequate and antiquated; and

WHEREAS, it would be in the public interest if the law on these subjects were reviewed and recommendations for needed sustantive and formal revision were made;

BE IT RESOLVED that the Legislative Council is directed to review existing law on the subject of medical practice, nurses, hospitals, drugs and criminal prohibitions in related areas and report its findings and recommendations to the Legislature.

Tentative Schedule for Alaska State Medical Association

18TH ANNUAL CONVENTION

ANCHORAGE, ALASKA, MAY 28 - JUNE 1, 1963

All meetings to be held at Anchorage-Westward Hotel unless otherwise noted.

TUESDAY, May 28, 1963—Organization and Business Meetings

WEDNESDAY, May 29, 1963

9:30 - 12:00—Departmental Reports and Business Meetings

2:00 P.M.—MR ED WIMMER, Cincinnati, Ohio "Medical Care Legislation"

2:30 P.M.—LOUIS DIAMOND, M.D., Boston, Mass. "Newer Knowledge of Blood and Blood Products"

3:00 P.M.—ELAINE UPDYKE, Sc.D. "Fluorescent Antibody Techniques"

4:00 P.M.—E. G. CHUINARD, M.D., Portland, Ore. "Orthopedic Problems of Childhood"

4:30 P.M.—WILLARD GOODWIN, M.D., Los Angeles, California "Renal Homotransplantation"

THURSDAY, May 30, 1963

9:30 A.M.—DONALD KETTLEKAMP, M.D., Anchorage "Webbed Fingers and Toes"

10:00 A.M.—J. T. LITTLETON, M.D., Sayre, Pa. "Polydirectional Body Section Radiography"

10:30 A.M.—C. HOWARD HATCHER, M.D., Palo Alto, California "Cartilage Tumors"

11:00 A.M.—CARROLL LARSON, M.D., Iowa City, Iowa—"Management of Bone and Joint Tuberculosis"

11:30 A.M.—WILLIAM HILLMAN, M.D., Nashville, Tenn.—"The Function of the Prosthetics Team"

12:00 Noon—DANIEL MOORE, M.D., Seattle, Wash. "Use of Regional Block Anesthesia in Acute Trauma"

AFTERNOON MEETINGS AT MT. ALYESKA, (Girdwood)

2:00 P.M.—JAMES WARREN, M.D., Columbus, Ohio "Some Problems in the Management of Coronary Artery Disease"

2:30 P.M.—PANEL DISCUSSION
PAUL HAGGLAND, M.D., Fairbanks, Alaska
ROBERT WHALEY, M.D., Anchorage, Alaska
FRED HILLMAN, M.D., Anchorage, Alaska
PERRY MEAD, M.D., Anchorage, Alaska
"Management of the Acute Multiple Injury Patient"

THURSDAY EVENING AT MT. ALYESKA

ALASKA HEART ASSOCIATION BANQUET
JAMES WARREN, M.D., Speaker

FRIDAY, May 31, 1963

9:00 - 10:30 A.M.—Business Meeting

10:30 A.M.—T. MANFORD McGEE, M.D., Detroit, Mich. "The Surgery of Deafness"

11:00 A.M.—LOUIS DIAMOND, M.D., Boston, Mass. "Aplastic Anemia: An Increasing Danger in Childhood and It's Treatment."

11:30 A.M.—DANIEL MOORE, M.D., Seattle, Wash. "Anesthesia for Obstetrical Problems"

12:00 Noon—CHARLES McCARTNEY, M.D., Chicago, Illinois. "Functional Uterine Bleeding"

2:00 P.M.—DAVID BASSETT, M.D., Seattle, Wash. "A New Approach to the Anatomy of the Hand"

2:30 P.M.—MERRILL J. WICKS, M.D., Tacoma, Wash.—"Russian Roulette with Bottle of Blood"

3:00 P.M.—CARROLL LARSON, M.D., Iowa City, Iowa—"Pathogenesis and Treatment of Low Back Pain"

3:30 P M.—GEORGE WICHMAN, M.D., Anchorage Alaska. "Disability Evaluation"

4:00 P.M.—TOM HARRISON, M.D., Alaska Native Hospital, Anchorage Alaska—
"Lipod Pneumonia as a Cause of Bronchiectasis in Alaska"

4:30 P.M.—THEODORE SHOHL, M.D., Anchorage, Alaska—"The Superior Mesenteric Artery Syndrome"

FRIDAY EVENING

ALASKA MEDICAL ASSOCIATION BANQUET AND DANCE—Ballroom of the Anchorage-Westward Hotel.
LEVI M. BROWNING, M.D., Speaker

SATURDAY, June 1, 1963

9:00 - 12:00 Noon—BUSINESS MEETING

* * *

Convention Note: Fishing season in the Anchorage area begins June 1, 1963. Upon request arrangements can be made for golf, tennis, swimming, horseback riding, flying, fishing and hiking.

Editorial Page . . .

ALASKA PSYCHIATRIC INSTITUTE

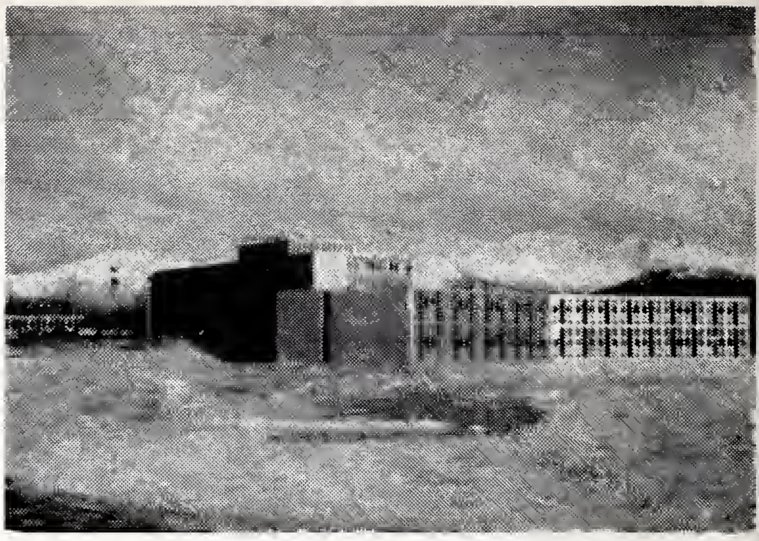
Residents of Alaska have in the year 1962 witnessed the end of the beginning and the beginning of a new phase in the state mental health program with the opening of the 225 bed Alaska Psychiatric Institute in Anchorage.

The initial phase began in 1956 with the passage of Public Law 830 by the 84th Congress of the United States. This law, signed by President Eisenhower on July 28, 1956, granted six and one-half million dollars for construction of the Institute and allocated the revenue from a million acres of federal land, to be chosen by the State of Alaska, for the year-to-year operation of the program. In 1956 it was estimated that the grant would be sufficient for the construction of 450 beds. In 1962 it was sufficient to complete only 225 beds although the supporting structures and operational installations are sufficient to allow for an eventual expansion to 450 beds.

In May 1962 the Institute, which is located on a 70 acre tract in the Goose Lake area four miles southeast of Anchorage adjacent to the new Providence Hospital and the Alaska Methodist University campus, was accepted from the contracting firm of Lease Co. of San Francisco. On October 15, 1962 its doors were officially opened to patients and on October 16 the first patient was admitted. During the first three and a half months of operation 50 patients have been admitted, 13 of which have already been discharged back to their communities. At the beginning of February the first 12 transfer patients from Morningside Hospital in Portland, Oregon were received at the Institute. A contractual agreement with Morningside Hospital calls for the reduction of the number of Morningside beds allocated to Alaskan patients by 10 per month either through discharge, community placement, death, or transfer.

The Physical Plant

The patients currently hospitalized are being cared for on the four acute wards on the first and second floors of the west wing. Each of these wards consists of six four-bed wards, a single room and a day room at the end of the wing. The male and female wards on each floor join centrally and share a common dining room and recreation area equipped with ping-pong tables, game tables and television. A 16 bed pediatric area in the east wing is scheduled for opening when staff becomes available and a 22 bed Day-Night Unit, for treatment of those patients requiring less than a full 24 hours a day hospitalization and follow-up care for patients in the community who have been discharged from the Institute, should be in operation by the end of April. The balance of the bed capacity is accounted for by the third floor geriatric ward and a ward of the east wing architecturally designed as an Industrial Rehabilitation Unit.



Alaska Psychiatric Institute

Other facilities in operation include a large gymnasium in which activities such as exercises, tennis, basketball, movies and dances are scheduled; a snack bar with soda fountain; a beauty shop; a barber shop; and a library. A large occupational therapy room equipped with kitchen appliances, sewing machines, looms, work benches and power tools will not be extensively utilized until an occupational therapist can be hired. A well equipped school classroom is now being used for impromptu classes in biology and Bible history taught by one of the psychiatric aides and will eventually be used for regular school classes when the patient load justifies. Religious services are scheduled three times weekly in the Chapel. The Institute is equipped with X-Ray, a clinical laboratory, physical therapy, and a surgical suite to care for the medical and surgical problems of patients. Medical specialists in the community are being utilized on a fee for service basis.

The Staff

The Alaska Psychiatric Institute currently has a staff of somewhat over 100 employees "aboard"—as Dr. Stanley Rogers, the Superintendent, describes it. Three of the four positions for physicians and about one half of the 125 budgeted nursing positions have been filled to date. The

Dr. Stanley J. Rogers

janitorial, dietary and laundry staffs, amounting to about 31 persons, are relatively complete as are the secretarial and operational staff of 26. Laboratory and X-Ray technicians, a psychologist, a dietician, and a physical therapist are employed while an occupational therapist and a social worker are still being sought. Under the direction of Natalie Mackler, formerly of the Massachusetts Mental Health Center, an intensive five day orientation course is being offered to new staff members and an ongoing 2-3 hour per week educational program is scheduled for staff members at various levels of professional training.

Dr. Stanley J. Rogers, Superintendent of Alaska Psychiatric Institute, was born in England in 1928 and completed medical school in Liverpool in 1951. After interning in the United States, he completed two years service with the Royal Army Medical Corps in East Africa. Upon returning to the United States in 1955, he embarked upon a residency in psychiatry at the University of North Carolina. Dr. Rogers was Clinical Director and Training Director of one of North Carolina's four State Hospitals, Memorial Hospital in Chapel Hill, prior to assuming the position of Superintendent of the Alaska Psychiatric Institute in October of 1962.

Dr. Francis Ivanichek is the senior physician at the Institute. A native of Yugoslavia, he came to the United States in 1952. In addition to his medical degree and board eligiblity in neurology and psychiatry, Dr. Ivanichek holds degrees in science and anthropology. His last position in Yugoslavia before coming to the United States was that of Director of the Anthropological Institute of the Medical School at the University of Zagreb where he was also an Associate Professor. During his career, Dr. Ivanichek has published monographs and papers in Yugoslavia, Poland, Germany and the United States, and has been granted fellowships and awards by the Ministry of Education in Yugoslavia and in Poland, the Humboldt Foundation in Germany, the World Health Organization of the United States, and the Wenner-Gren Foundation for Anthropological Research in New York.

Dr. Virginia Gorton, who arrived in Alaska on January 4, 1963, is the most recent addition to the medical staff of the Institute. Dr. Gorton, a native of Portland Oregon, had an R.N. degree, a B.S. in Nursing Education, and four years of administrative and teaching experience in nursing before attending the University of Tennessee Medical School from which she received her M.D. in 1947. She had her psychiatric training at Patton State Hospital, Mendicino State Hospital, Langley Porter Clinic in San Francisco, and Western State Hospital at Fort Steilicum, Washington. She has served on the staffs of Western State Hospital in Tennessee, the California State Mental Health Service, and the Mental Health Institute in Mt. Pleasant, Iowa. Dr. Groton is a member of the American Psychiatric Association and holds a faculty appointment on the medical school faculty, College of Medical Evangelists, in California.

Millicent Tschaepe, Nursing Director of the Alaska Psychiatric Institute, has been employed by the Division of Mental Health, Department of Health and Welfare, since February, 1960. Prior to coming to Alaska, Miss Tschaepe held the position of Assistant Director of Nursing at the New Jersey State Hospital in Trenton, New Jersey, and was on the faculty of Columbia University as an Instructor in Mental Health.

Key non-medical personnel includes Mr. Paul Kenneth Porter, the Administrator, who has had experience on the administrative staffs of the hospital ship U.S.S. Haven; the U.S. Naval Hospital in Memphis, Tennessee; the Wesley Hospital and Nursing School in Wichita, Kansas; Davies County Hospital in Washington, Indiana; Department of Medical Service, Government of Guam; and the Clark Country Hospital in Jefferson, Indiana. Dr. Mitchell Wetherhorn, the staff psychologist holds the degrees of B.S., M.S., and Ph.D. from Florida State University and has served with the Mental Health Centers in Augusta, Georgia; Columbia, Georgia; and Crookston, Minnesota, and also with the St. Peter State Hospital in St. Peter, Minnesota.

Occupational Therapy Workshop

The Patients

Alaska Psychiatric Institute was conceived and designed as an intensive care unit for treatment of patients with "major mental illness," as defined by the Alaska Mental Health Act of 1957 to include schizophrenia, manic depressive psychosis, involutional states, organic brain syndrome, and severe mental retardation, but **not** to include alcoholism, drug addiction, psychopathic personality, or neuroses.

The aim of the Institute is that of short term therapy with return of the patients to the community rather than chronic custodial care. All modalities of therapy including electric shock and insulin are available, however it is anticipated that most cases will be handled by individual and group psychotherapy with the adjunct of tranquillizing drugs. Since the Institute is designed entirely as an "open-door" facility, there are no maximum security provisions to allow for the care of the criminally insane of those judged incapable of standing trial for reasons of insanity.

The first 40 patients admitted were primarily those acutely ill individuals for which the Institute was designed, however the initial transfers from Morningside have been long term institutional patients, primarily of native extraction, with some degree of mental retardation and/or chronic brain syndrome. Of the approximately 250 Alaskan patients remaining at Morningside, it is estimated that about 100 are retardates and another 100 suffer from forms of chronic brain syndrome. Many of these patients would be admitted to Harborview Nursing Home in Valdez were beds available. Some could be assimilated back into Alaska communities were foster homes available or social service contact sufficient to prepare families for their return. As things stand now, they could more than fill the Psychiatric Institute within the next two years.

Aside from the Morningside transfers, all admissions to A.P.I. are handled through the regional mental health teams in Fairbanks, Anchorage and Juneau. Potential patients are referred by private physicians, public health nurses, police or other responsible persons to the teams which consist of a psychiatric social worker and a clinical psychologist with psychiatrists available at least on a part time consulting basis. The mental health teams screen many cases for which provisions other than admission to A.P.I. are arranged. In cases of emergency a telephone call from a reliable referring person to the regional mental health team can pave the way for direct admission to A.P.I. from an outlying area without necessitating a visit to the mental health team. In areas where a general hospital is available emergency cases are usually admitted to that facility pending screening by the mental health team.

Commitments to the Psychiatric Institute are of three types: 1) voluntary, in which the patient signs the admission forms; 2) by application of an interested party or official of the court accompanied by a physician's certificate stating reasons for admission; and 3) by judicial commitment. Discharge conferences are held weekly with representatives included from the Greater Anchorage Health District, the Office of Vocational Rehabilitation and of course the regional mental health team which again assumes responsibility for the patient upon discharge. When the Day-Night care unit is activated within the next several months, some of the Anchorage patients will continue being followed by the Institute staff on

Pediatric Ward Equipment

an out-patient basis. Patients from outlying areas may also be followed in the Day-Night units following discharge if suitable foster homes can be found in the Anchorage area.

The Community

Community participation is an integral part of the program of Alaska Psychiatric Institute, for the patients need to feel that people are interested in them. The doors are not so much open for the patients to go out as they are for the community to come in. Mrs. Mildred Mantle, a 19 year resident of Anchorage with considerable experence in voluntary health agency program, has assumed the position of Community Coordinator and Director of Volunteers. She has arranged for community organizations to give parties for the patients and to play Bingo and square dance with them In lieu of a full-time occupational therapist, volunteers help interested patients with cooking, sewing, knitting and craft work. A 2,000 volume circulating library has been acquired through community contributions and catalogued by two experienced volunteers. Another community participation project is the acquisition and renovation of used wardrobes for patients without adequate clothing of their own. The gymnasium-auditorium is available for community use, with Alaska Methodist University being the first group to utilize it regularly. Starting this summer the Community College class in practical nursing will have their psychiatric training at A.P.I.

The Future

As it now stands, Alaska Psychiatric Institute is not in itself the answer to the mental health problems of Alaska although it augers well for being an excellent and perhaps even an avant-garde facility for the acute treatable psychotic patient. Its excellent potential for the treatment of this category of mental illness serves to point out in sharp contrast deficiencies in other areas of the treatment of the mentally ill. Alaska has no facilities for the alcoholics, the drug addicts, or the criminally insane. No program or facility exists for mentally retarded children in the trainable group and Harborview Nursing Home in Valdez is filled to its 50 bed capacity with mentally retarded adults while double that number of retardates are hospitalized in Morningside awaiting transfer to Alaska.

Snack Bar in Readiness

Gymnasium in Action

The new Psychiatric Institute may in the near future have to adapt itself to help at least temporarily in meeting these mental health needs. Success at this point may depend to some extent upon its adaptability to the mental health needs of Alaska as they arise. Finally, the success of the mental health program depends not only upon the ability to regulate patients in the hospital setting but also to pave the way for their readjustment in their communities. Currently the responsibility for this vital phase of the program lies squarely on the shoulders of the already heavily workladen mental health teams. Much effort will be necessary to prepare communities and families to accept responsibility for their mentally ill members once they are sufficiently regulated to be maintained outside of an institution. Without this effort an increasing number of the mentally and emotionally inadequate will continue to find the polished halls of A.P.I. like the grassy lawns of Morningside, easier to adjust to than the rigors of an Alaskan winter.

—Elizabeth A. Tower, M.D.
Managing Editor

Letters to the Editor . . .

January 30, 1963
P. O. Box 370
Mt. Edgecumbe, Alaska

Robert B. Wilkins, M.D.
718 K Street
Anchorage, Alaska

Dear Bob:

Occasionally one puts off writing a letter because of an emotional hookup in the circumstances causing the letter to be written. I find myself in exactly that position as I have gotten ready to write you several times in the past three weeks.

After nearly thirteen years of Alaskan residence and association with the medical fraternity of the state and active membership in the Society, I am being transferred to the Oklahoma area Office of the Division of Indian Health, U.S. Public Health Service. Naturally, I leave Alaska with mixed emotions and pleasant memories.

One of the highlights of my Alaskan residence was the honor paid me by our Society in electing me as their President. The associations and friends that I had were and will continue to be very valuable to me.

I realize that some of us are different in our thoughts about the practice of medicine but basically we are the same, with an ultimate goal of providing good medical care to all persons, regardless of race, color, creed or status of their finances. There is a middle course that should be the answer and I sincerely believe that this course must be laid out and navigated by the physicians of America. If the leadership cannot provide the proper navigation just as the captain and officers of the crew of a ship must provide, someone else will be found to do it for them. There is room in this medical world for all of us, whether we be in private, group, corporate, or governmental medicine.

As I leave Alaska, and not having a current copy of the constitution at hand, I am wondering if there is provision for an Associate Membership available to me. I would like in some small way to retain my association with the Society. My address after February 10 will be 4646 N.W. 60th, Oklahoma City, Oklahoma, and I will be happy to hear from you there.

Sincerely,
"Mac" (B. E. McBrayer, M.D.)

Editor
ALASKA MEDICINE

As a neophyte politician, who has run for elective office twice and been defeated both times, there are a few things I feel qualified to say to the medical profession which, I hope, will be taken in the spirit in which they are given. I realize that when a woman runs for political office she needs either a burning issue to put her over in the eyes of the electors or a tremendous amount of help and favorable publicity. Both times I ran for office I was relatively unknown and the gains I made will stand me in good stead when I run again in 1964, therefore, I feel I can speak with some degree of authority.

Never has the physician had so much to gain by becoming interested in the politics of his state and nation and so much to lose by remaining apathetic and asking only that "I be allowed to practice my profession in peace."

Politics is not a "dirty" business nor are politicians a breed apart. If politicians are "nuts," "crooked" or "dirty" then **you,** as a voter, are compounding the error by voting for the very people you deride. Look around you at the men you have elected to run this state and nation and to write the laws. Are they competent to do the job you sent them to Juneau or Washington to do or have you chosen fools who aren't even able to run their own lives and businesses? I think you will find that the majority of our elected representatives are not only successful business men but successful in their personal lives as well. The politician of today is a new breed. He is a man who sees the need to serve his government and is willing to give up his time to serve the very people who snear at him.

During my campaign I was asked why I was running for office. My answer was as brief as I could make it:

"The privilege to speak my mind and complain about my government carries with it the responsibility to do something about it."

For the most part, campaign assistance from the members of the medical profession or their wives was woefully lacking during this last campaign. For a group with so much at stake, depending on the politics of the government, this disinclination to face the facts of life is pathetic.

Whether you are interested in politics or not—remember—politics is interested in you.

Whether or not this country follows the path to socialism depends on you and your effectiveness in combatting this trend on an active level. Again, this year, we will see an attempt made to pass some type of medicare legislation despite the fact that in many states Kerr-Mills legislation has not yet been implemented and in others there seems to be an attempt to stifle its effectiveness. Medicare is just one item out of many types of "social" legislation that will be introduced this year.

On the state level remember that, last year while you were working and practicing your profession "ostrichlike," the present governor vetoed a bill which would have permitted professional people to set up tax-deductible pension plans.

To those of you who do not receive AMPAC political stethoscope or who do not bother to read it, let me quote Dr. Frank C. Coleman of AMPAC's board:

> "AMPAC priorities for this year are: 1. Renew AMPAC and state PAC membership and recruit new members; 2. Give what you can afford, not minimums; 3. Get active in the party of your choice; 4. Get the habit of additional candidate support; 5. Use the political education programs available; 6. **Start Now.**
>
> The most important lesson AMPAC learned: Help to candidates was successful in direct proportion to the efficiency of our candidate support organizations. Good organizations got results in case after case; poorly organized candidate committees, providing little more than financial assistance, just didn't do the job. Money alone is not the answer."

It is vitally important that the candidate, who thinks as the medical profession does be given all assistance possible. And this means helping in the little jobs like licking stamps and envelopes if that is all you can do. Without "likethinking" candidates and elected officials the medical profession is going to be hamstrung with governmental red tape. In this world you work for what you get and if you don't work—**you get what you deserve.**

My personal experience has shown me that the majority of the medical profession could "care less." With a little help from the profession and the auxiliary many more "professionally oriented" candidates could have won. Not only do we need your help—**you need us.**

For your information both political parties are trying to keep full time offices open. Both parties need, not only your financial support, but also your moral support and assistance in maintaining these offices. Regardless of your political party—for your own sake—get active in the party of your choice. Then let us see if the physicians of Alaska can carry out the six steps Dr. Coleman stressed.

Marjorie G. Fitzpatrick
(Mrs. James J. Fitzpatrick)

INDIVIDUAL RESPONSIBILITY PLAN

Editor, **Alaska Medicine**
742 K Street
Anchorage, Alaska

Dear Sir:

For the past 1½ years the physicians of the San Fernando Valley District of the Los Angeles County Medical Association have been using a system under which third party interference and patient complaints about their insurance coverage have been greatly reduced. It is the Individual Responsibility Plan, IRP, and ". . . 36% of our members are using this simplified insurance form. . . . It has been well received nationally."

I requested copies of their forms and literature, and hope to have copies of two of their brochures **inclosed with this issue of Alaska Medicine."**

Thus, I.R.P. ". . . is a practical plan of action designed to place doctors, patients, and third parties into their proper relative roles of responsibility. It keeps the doctor responsible to the patient, the patient responsible to the doctor. It keeps the government or the insurance company out of the practice of medicine, and **keeps the doctor out of the insurance business."**

Sound good? That's why I am writing this letter about I.R.P. so that other Alaskan physicians can learn more about it by reading the inclosed pamphlets, contacting their colleagues in the LA area, and later by bringing it up at the State Convention in May.

Sincerely,
John B. Fenger, M.D.
Box 202
Homer, Alaska

Women in Politics

Look like a girl
Act like a lady
Think like a man
Work like a dog!

ALASKA DEPARTMENT OF HEALTH NEWS

EDWIN O. WICKS, M.D., Director

Medical Self-Help courses have been given in major centers of Alaska through the cooperation and leadership of private practitioners, and full support from the State Division of Civil Defense. Latest community to offer the course is Juneau, where endorsement of local physicians has resulted in plans to give survival information to several hundred persons in the next four months. Jerry Mugaas, Red Cross Instructor in First Aid and representative of the International Rescue Council, integrates Med Selp-Help with his advanced courses and presently is teaching police, fire and safety personnel the combined material.

* * * * *

Further assistance in medical aspects of disaster-recoil will be gained from Warren Griffin who is stationed with the Division of Public Health by the USPHS as Health Mobilization Advisor. Mr. Griffin, formerly in charge of the Native Village Sanitation Project, joined the Federal service for this particular mission early in February He will work closely with hospitals and local medical societies to extend capabilities for handling disasters of any type and magnitude. He will have duties in connection with the Civil Defense Emergency Hospitals stored at Seward and Fairbanks and the stock-piling and control of medical supplies. His office is with other Health and Welfare personnel at 327 Eagle Street, Anchorage.

* * * * *

During May a two-week course in the hottest topic of diagnostic bacteriology, fluorescent antibody techniques, will be given by the Southcentral Regional Laboratory and the PHS Communicable Disease Center. Dr. Elaine Updyke will come from Atlanta to lead the course for State, Federal and private laboratory personnel of Westward Alaska. Dr. Updyke, who holds an Sc.D. from Johns Hopkins, will also speak on the 29th at the annual convention of the State Medical Association.

* * * * *

Frank Pauls, Laboratories Chief for ADPH and president of the Alaska Public Health Association, in conjunction with Dr. Francis Phillips, has arranged a seminar on tuberculosis to be presented during the August meeting of the AAAS in Anchorage. Cooperating with a team from CDC are also the Alaska State Medical Association and the Alaska Tuberculosis Association. The sessions coincide with an increased effort to find and treat every active TB case in the State and to heighten understanding that the disease can be eradicted. Several hundred scientists from all over the country will register for the AAAS conclave.

* * * * *

Dr. Jack Lesh, M-CH Chief for the State, reports that during 1962 nearly 3100 orders or repairs of glasses were processed by his unit. Even at wholesale costs the sum involved is $20,000 or more and the paper-shuffling anchors down one clerk full time. The Division of Public Health engages in this activity in default manner—nobody else will take on the job although the needs of youngsters in the remote villages are recognized by everyone. Comments on resolution of the dilemma are solicited.

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The city of Kenai has worked out an agreement with Bruce Adams, Southcentral Regional Sanitarian, whereby environmental health control measures can be stressed for the peninsula town. Kenai will underwrite salary costs so that a sanitarian can be stationed nearby for intensive work with the City Council and residents. Kodiak has a similar agreement.

* * * * *

More than two hundred thousand dollars worth of work was done during the past year to improve sanitation practices of Native villages and small communities by a joint effort of the Environmental Health Branch of ADPH and the Office of the Governor through Robert L. (Tex) Hoffman, Director of Rural Development. Water supplies, privies and refuse disposal areas were engineered, constructed, and put into operation. Sounding very primitive in other parts of the country these simple matters are of pressing concern in the Arctic and any advance is a boon. Similar projects were carried out in conjunction with the Alaska Native Health Service, and the latter has a like program of its own.

AMERICAN ACADEMY OF GENERAL PRACTICE NEWS

JOSEPH B. DEISHER, M.D., President Alaska Chapter

Last September, as is the yearly custom, the AAGP held a State Officer's Conference in Kansas City, Missouri. Prior to that conference a group of the leaders of the organization had met to re-evaluate the **purposes and functions of the Academy.** The purposes were re-defined as follows:

1. To assure the public of the continuing availability of a competently trained modern family physician.

To do this:

2. Assure a continuing supply of modern general practitioners to function as family physicians, and
3. Assure hospital privileges commensurate with the general practitioners experience and training.

All across the United States lip service is being given to the concept of the doctor of medicine who assumes comprehensive and continuing responsibility for the medical care of the patient, and his family if desired, regardless of sex. However the actual technical details of the education and training which would lead to the future and increasing production of medical practitioners of this caliber have not been worked out by the medical school authorities, who are clearly biased in the direction of specialization for the majority of their graduates. The product which we seem to require might be termed the "undifferentiated medical student or physician."

Here in Alaska, with the vast expanse of territory and the scarcity of centers of population, the general practitioner will be the back-bone of medical practice for many years to come. And it is not only in the rural and civilian urban areas that general practitioners are needed to care for the common medical problems of families; approximately one thousand general practice medical officers are required by the Department of Defense in the fiscal year starting July 1, 1963.

Since it's inception in 1947 the AAGP has had as one of its most important aims a continuing education of the general practitioner. In order to maintain certain standards the Academy has examined courses and set up requirements for meetings which would assure that these programs were directed for the benefit of the general practitioner. The members of the Academy are required to accumulate 150 hours of acceptable educational effort in each three-year period. With the organization of the Alaska Chapter we hope to be able to supply the vast majority of these hours within our State for the vast majority of our members.

It appears that now the AAGP must investigate the undergraduate field and apply its influence on the medical school authorities to assure that the supply of general practitioners will continue throughout the coming years so that the acknowledged benefits of the utilization of the family physician will continue to accrue to the American people.

* * * * *

The Committee on Medical Economics of AAGP met in Kansas City on December 15 and 16 to consider **relative value scales.** Its first action was to reaffirm the 1958 stand of the Congress of Delegates that "relative values are being studied widely and we encourage members to participate through their local, State, and county societies in the study of these problems."

The committee also unanimously agreed "that in view of the growth of prepaid medical care, relative value scales are probably inevitable; furthermore, the committee feels that such scales, establishing a fair and equitable relative value between various medical and surgical procedures, will tend to answer some of the criticisms both from within and without the profession concerning fees for medical and surgical services. The committee takes no position on the monetary value to be assigned to relative units; this will vary from community to community. The committee emphatically insists, however, that value **units must be established** for procedures **without relation to the practitioners performing the service,** leaving the qualification of practitioners to the central authority of licensing agencies of the respective sovereign states. Special qualifications of practitioners should be recognized through establishment of suitable 'unit values' for consultation services rendered patients by other practitioners."

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The National Assembly of AAGP will be in Chicago from March 29 to April 4, 1963. Approximately 15 hours of Category I credit will be given for attending the entire meeting.

WOMEN'S AUXILIARY NEWS

Compiled by

MRS. GLENN B. CRAWFORD

PRESIDENT'S MESSAGE

We hope to see many of you at your State Medical Convention to be held in Anchorage on May 28th through June 1st. Mrs. Thuss, President of our Women's Auxiliary to the A.M.A. will be here to advise and encourage us. She is a charming woman from Alabama whom I hope you will all have an opportunity to meet.

Mrs. Asa (Evelyn) Martin and Mrs. Calvin (Rita) Johnson, our capable convention chairmen, are at work on plans for the annual meet. They would welcome any suggestions you may have with regard to making this a more successful and enjoyable time for all.

You will soon be receiving new copies of the revised Constitution and By-Laws of our State Medical Auxiliary. Any proposed changes must reach our By-Laws chairman, Mrs. Wm. (Alice) Maddock, Star Route A Box 1029, Anchorage no later than April 15th please.

In the next Newsletter, which will be mailed within a week, you will find a questionaire which I would appreciate having filled out and returned to me as soon as possible or before April 1st. Also enclosed in the Newsletter will be a proxy voting form for your convenience if you are unable to attend the convention.

Please let me clear up a point regarding membership of women other than medical wives in our Auxiliary. They may be members of the local organization but only associate members of the State Auxiliary. They would not be eligible to hold a state or national office.

Many, many thanks to those of you who responded so well with comments, suggestions and news for your Newsletter. Please let us hear more from you!

Sincerely, Grace Cates

LEDERLE SYMPOSIUM

Many physicians and wives enjoyed the Lederle Symposium held in Anchorage at the Westward Hotel on February 24th. We were invited to attend the meetings with our husbands and were treated to a morning coffee and luncheon. A most enjoyable reception was held in the evening following the meetings. It is an annual event to which we all look forward and do appreciate.

Our thanks to Lederle Laboratories!

CONVENTION PROGRAM

The annual meeting of the Alaska State Medical Association and Auxiliary will be held in Anchorage this year from May 29th through June 1st. When definite plans are formalized, programs will be mailed to you. Tentative plans for the women are as follows:

Wednesday Morning—May 29

Executive Board Meeting

Wednesday Afternoon—May 29

Registration and Bavarian Coffee

Thursday Morning—May 30

Trip to Mt. Alyeska and Portage Glacier with a ride on the chair lift and lunch, perhaps at the top of the mountain. Here you will have an opportunity to meet and talk with our National Auxiliary President, Mrs. Thuss, who will be our guest and speaker for the convention.

Thursday Evening—May 30

Heart Association Dinner

Friday Noon—May 31

Luncheon and fashion show featuring physicians' wives as models.

Friday Afternoon—May 31

Business Meeting of the Alaska State Medical Auxiliary

Friday Evening—May 31

Medical Society Banquet, Anchorage-Westward Hotel Ballroom

Saturday Morning—June 1

Breakfast and round table discussion for incoming and outgoing officers and other interested members.

Saturday Afternoon—June 1

Tour of the highlights of the new Alaska Psychiatric Institute, the new Providence Hospital and Alaska Methodist University.

We are all looking forward to seeing you at the Convention!

"PROFILE" OF MRS. WM. BUGH

(President of the Fairbanks Medical Auxiliary)

Janet Moran was born in Michigan, and lived during her school years in Northern Indiana. She received her R.N., B.S. and M.S. degrees from Indiana University. She worked in the department of Obstetrics at the Indiana University Medical Center and was married to Dr. C. William Bugh in 1957.

In November, 1959 they moved from Indianapolis to Fairbanks, after a previous trip that summer. Their family consists of Jennifer 5, Michael 2½, and Jeffrey 1½, plus one very large German Shepherd and one very small toy poodle.

Janet has been active in Auxiliary work since coming to Fairbanks, and is presently the president of the Fairbanks Auxiliary. She is active in the Republican Women's Club, and spends her summers gardening and "greenhousing."

MUKTUK MORSELS

A Column Devoted to
Medical News in Alaska

Compiled by

HELEN S. WHALEY, M.D.

GENERAL: The Fifth Annual Lederle Symposium was held in conjunction with the Anchorage Medical Society and the Alaska Chapter of the American Academy of General Practice on Saturday, February 23, 1963, in Anchorage. This was a symposium on traumatic injury.

Guest speakers included Dr. Dean Crocker, Anesthesiologist, Children's Hospital Medical Center, Harvard Medical School, Boston, Massachusetts, who discussed resuscitation of the newborn, including assisted respiration and the use of hypothermia in neurological disease with particular reference to head injury. The treatment of soft tissue injuries and the management of burns were summarized by Dr. William T. Fitts, Jr., Professor of Surgery, University of Pennsylvania School of Medicine.

Of considerable interest to the many skiers in the audience was the discussion of athletic injuries to the upper and lower extremities, with particular reference to ski injuries, outlined by Dr. Adrian E. Flatt, Associate Professor of Orthopedic Surgery, State University of Iowa College of Medicine.

Medical officers in charge of the various U. S. Public Health Service field hospitals in Alaska attended a week-long convention in Anchorage beginning the week of February 18th. Considerable emphasis was placed on the changing role of the Alaska Native, which was discussed by Dr. Margaret Lantis, well-known Alaskan anthropologist currently stationed in Washington, D. C. The relation of the Children's Bureau to a number of programs including the Crippled Children's services, studies to reduce infant mortality, etc. were discussed by Dr. Edith Sappington, San Francisco, Regional Director of the Children's Bureau for the western states. The program was organized by Drs. K. Kasuga, Area Medical Officer, and Holman R. Wherritt, Medical Officer in Charge in Anchorage. Participating Public Health Service officers were: Dr. Richard T. Light, Barrow; Dr. William G. Edwards, Bethel; Dr. Ward B. Hurlburt, Kanakanak; Dr. David Turner, Kotzebue; Dr. Rollin W. Pederson, Tanana; and Drs. R. K. Hampton and Robert Hampton of the Mt. Edgecumbe Hospital.

A very successful oral polio immunization program was launched on Sunday, January 27th, under the sponsorship of the Anchorage Medical Society in cooperation with the U.S.P.H.S., Alaska Department of Health, U.S. Air Force and Army, the Greater Anchorage Health District, and a number of voluntary agencies including the Anchorage Independent School District, the Anchorage Pharmacy Association, Nurses Association, and the area PTAs.

Over 60,000 people in the Anchorage region received Sabin Type I oral polio vaccine. Simultaneously the same immunization was given in Palmer, Chugiak, Eagle River, Alyeska, Glenallen, Homer, and Seldovia. Types II and III will be given at six weeks' intervals in March and April in the same communities. Cordova, a year ago, received Type I. Fairbanks held their initial oral polio clinic in March, immunizing over 10,000. In cooperation with U.S.P.H.S. and the Anchorage Medical Society, Point Barrow and Barter Island also received Type I polio vaccine. A similar program is planned for Nome and possibly Bethel in the near future.

Under the auspices of the Western Interstate Commission on Higher Education, Dr. Robert Hewitt, Director of the Mental Health Training and Research Project and Dr. Jerome Levy, Director of Staff Development Programs, both from Boulder, Colorado, held a number of meetings in Anchorage during the week of February 18th. Involved groups were a number of government agencies, including the United States Public Health Service, Arctic Research Center, the Youth and Adult Authority, the Office of Vocational Rehabilitation, as well as the Mental Health Association and the Mental Health Committee of the Medical Society.

A proposal was formulated to set up education programs for both physicians and members of the general public frequently involved with mental health problems, such as ministers, public health nurses, etc. It was noted that Alaska has a number of mental health problems frequently seen in other northern countries, including a high suicide, alcohol, and homicide rate, all of which are complicated by great distances and a lack of adequate facilities and trained personnel. It was felt desirable that more fundamental research into the causes of these problems be done, as well as better educating the general public.

FAIRBANKS: 1963 officers of the Fairbanks Medical Society include Dr. Donald Tatum, President; Colonel Douglas Lindsey, Fort Wainwright, Vice-President; Dr. William James, Treasurer; and Dr. George Leih, Secretary. Dr. Joseph Ribar is the new chief of the St. Joseph's Hospital medical staff. A new laundry and powerhouse are to be added to the hospital in 1963 and it is anticipated that new beds will be added in 1964.

Three new physicians have entered practice in Fairbanks, affiliated with the Fairbanks Medical and Surgical Clinic. These include Dr. Nicholas Deely, who received his M. D. from the University of Amsterdam, The Netherlands, in 1955, and had his pediatric training at the Montreal Children's Hospital and the Royal Victoria Hospital under the auspices of the McGill University Medical Center. He spent a brief period of time at the Moose Factory Indian Hospital, Ontario, Canada, and was in private practice in pediatrics in Glenclift, New Hampshire, where he was also senior physician at the New Hampshire State Sanitarium. He holds membership in the New Hampshire Medical Society; Pediatric Society; and Trudeau Society. He is Board eligible and will practice pediatrics.

Dr. Joseph Kelly Johnson II, who is a member of the American Board of Surgery, and who graduated from the University of Texas Medical Branch in 1943, has joined the clinic as a surgeon. He formerly practiced in Jacksonville and Houston, Texas. He is a fellow of the American College of Surgeons and of the Texas Medical Association. He has authored a number of papers, including discussions of tumors of the major salivary glands; radical breast operation for cancer; and mechanical heart-lung apparatus.

The third new physician to join the Fairbanks Medical and Surgical Clinic and the Alaska State Medical Association is Dr. Robert F. Faulkner.

Medical meetings were attended by Dr. Donald Tatum, who went to the American College of Physicians Meeting on pulmonary function in California, and Dr. Paul B. Haggland, who attended the Lederle Conference in Anchorage. Dr. George C. Leih, formerly of the Fairbanks Medical and Surgical Clinic, has joined Dr. Charles W. Bugh in general practice.

GLENALLEN: Dr. Jim Pinneo and his family are furloughing at Ventor, New Jersey, and will be back in July 1963. He attended the American College of Surgeons Meeting in the fall and plans to attend the AMA meetings in Atlantic City in June. Dr. Chester L. Schneider has been alone at the Faith Hospital except for 2¼ months' help from Dr. A. C. Hirschfield of Oklahoma City. Dr. Hirschfield assisted under the auspices of a Short Term Missionary Program for private practitioners sponsored by the Christian Medical Society. These men offer their services for periods of weeks to months at their own expense.

The twelve-bed addition is planned for the summer of 1963 for the Faith Hospital. Dr. Schneider reports that the people of the Copper River Valley took full advantage of being included in the Sabin Oral Vaccine Program which was made available for one week since transportation and communication are not conducive to a one-day "crash" program in an area with such a scattered population.

PALMER: 1963 President of the Valley Presbyterian Hospital Staff is Dr. Vincent Hume. Dr. Arthur Colberg is vice-president and Dr. Boyd A. Skille is secretary-treasurer. A highly successful Sabin Oral Sunday Vaccine Program for the Matanuska Valley was chairmaned by Dr. Clarence Bailey.

CHUGIAK-EAGLE RIVER: Dr. Marshall Simpson supervised the Sabin Oral Sunday Vaccine Program for the wide area between Palmer and Anchorage. He was assisted by U.S.P.H.S. hospital physicians, Drs. Bill Mentzer and George Sperry. Dr. Simpson is also serving as secretary of the Anchorage Medical Association for 1963.

CORDOVA: Dr. Duane Drake, Anchorage radiologist, was an eminently qualified judge for the Cordova Iceworm Festival Queen Contest. Dr. John Chapman attended the Lederle Symposium.

SEWARD: Dr. Ernest W. Gentles reports that he has recently moved into a new office building, with his wife assisting him as his office nurse. Dr. Joseph Deisher recently returned from the East Coast.

SELDOVIA: Drs. Cary and Betty Whitehead sponsored the Oral Polio Clinic for this region.

HOMER: A week-long Oral Polio Program was set up in Homer for the lower Kenai Peninsula by Dr. John Fenger.

KENAI-SOLDOTNA: Dr. Paul G. Isaak accompanied by Dr. Charles St. John of Anchorage in the latter's Comanche to the General Practice Review in Denver January 13th through 19th.

Dr. Isaak reports that the return flight from Denver to Sacramento via Las Vegas "was beautiful with the Grand Canyon, Death Valley, Hoover Dam, and Lake Tahoe viewed within a few hours. However, the trip from Sacramento to Anchorage took one week with a series of smog and fog landings and take-offs." There was several days' delay in Fort Nelson, British Columbia. All in all, Dr. Isaak reported that it "was an enjoyable trip but that he surely did learn to appreciate the gadget in the plane called an ADF". Dr. and Mrs. Isaak plan to visit Denmark this spring.

Dr. Alan Barr plans to open an office for the practice of medicine in Kenai.

SITKA: Dr. Benjamin McBrayer was transferred February 1, 1963 to the position of area medical officer in charge, Oklahoma Area Office, Division of Indian Health, Oklahoma City. He has been in charge of the Mt. Edgecumbe installation for a number of years and served in 1961 as President of the Alaska State Medical Association. He stated that he had greatly enjoyed his association with all the health agencies in Alaska and that he would miss them very much.

Dr. Phil Moore was recently elected to the Board of Governors of the American College of Surgeons. Dr. Tim Moore is a certified lay reader, St. Peter's By-the-Sea Episcopal Church, and will attend the Annual Convocation of Lay Readers in Fairbanks in April. He also recently became a member of the Pan-Pacific Surgical Association. Dr. Bob Shuler is President of the Board of the Sitka Independent School District.

JUNEAU: Dr. William H. Whitehead, freshman Democratic representative from Juneau, has introduced several new and somewhat controversial bills. One would amend the State's abortion law and action is still pending on this. A measure was passed which would permit citizens of Canada and the United Kingdom, as well as the United States, to practice in Alaska. An amendment to allow any foreign practitioner who passed the State Medical Board Examination to practice in Alaska was defeated.

Dr. and Mrs. Robert S. Smalley had their second child, a girl, in February.

St. Ann's Hospital announces the new officers of the medical staff Executive Committee to be: President, Dr. Henry Wilde; Vice-President, Dr. Homer Ray; Secretary, Dr. Joseph Riederer.

KETCHIKAN: Dr. Ralph W. Carr, who is pictured with his wife Jane while in attendance at the banquet of the Congress of the International College of Surgeons at the Waldorf-Astoria, New York, in September 1962, will be inducted as a Fellow of the College at the 18th Annual Congress in Los Angeles in April 1963. Dr. Carr is President-Elect of the Alaska State Medical Association and will take office following the Anchorage meeting in late May of this year. At the same time. Mrs. Carr will assume the duties of Womens' Auxiliary President.

Dr. and Mrs. Carr

ANCHORAGE: In early February of this year, Mrs. E. Wells Ervin became the wife of Dr. A. S. Walkowski, pioneer Anchorage physician The new Mrs. Walkowski is active in many community activities including the Alaska Festival of Music.

The old Providence Hospital, now known as St. Mary's Residence has opened its doors as a facility for the chronically ill at a cost to the patient of $20 per day.

Returning to the State after a 5 year absence is Dr. Thomas R. McGowan who will take over the position of Regional Health Officer at Anchorage about March first. Dr. McGowan served two years as Senior Field Physician on the Aleutian Chain runs of the floating health center HYGIENE, last of the Territorial Health Department's boats. He had served a residency in dermatology at the University of Iowa and was in private practice at Bellingham, Washington before becoming interested in public health.

Dr. McGowan was born in Mississippi and earned BS and MD degrees at Emory University. In 1957 he enrolled at The Johns Hopkins University School of Hygiene and Public Health and earned the Doctor of Public Health degree in 1960. Thereafter he was on the faculty in the field of pathobiology and operated the International Center for Medical Research and Training located at Hopkins. During the past two years he has spent much time in Calcutta establishing health professions training units for India.

Anchorage physicians have been on the move for the past few months. Dr. Glenn Crawford, 1963 President of the Anchorage Medical Society, recently returned from Europe, where he toured hospitals in England and France. Alaska State Medical Association President, Dr. William J. Mills, attended the orthopedic conference in Miami, Florida. On his return he gave a series of lectures at Vanderbilt University on frostbite and children's orthopedic problems in the Arctic. He also visited Washington, where he held further conferences with the U.S. Navy on the frostbite project.

Dr. Rodman Wilson, 1964 President-elect of the Anchorage Medical Association, took a quick trip to Portland, Oregon, where he attended the Northwest Regional American College of Physicians meeting.

Dr. J. Ray Langdon plans to attend the Mental Health Council of the AMA in Chicago in March. Pediatrician Dr. Don Val Langston, 1964 President-elect of the Providence Hospital Staff, visited a number of Texas medical centers in December, accompanied by his wife and new daughter. Dr. Elizabeth Tower was one of 450 participants in the President Kennedy 50-mile hike from Palmer to Anchorage and was one of the 70 or so individuals to complete this hike, coming in as the third woman. Psychiatrist Bill Rader recently accompanied an Alaska Department of Health mental health team to the Bethel region.

New offspring of Anchorage physicians include a son for Dr. Nancy Sydnam and a daughter for the Langdons.

Anchorage businessman Bruce E. Robinson has been appointed administrator of the new Presbyterian Community Hospital in Anchorage, which is tentatively scheduled to open on May 1st. He was formerly comptroller in the Northern Commercial Department Store in Anchorage. Dr. George E. Hale has been selected acting chief of staff of the new hospital. Dr. Winthrop Fish was re-elected chief of staff at the new Providence Hospital.

Dr. William Caughran is assisting in the establishment of a new cold storage plant for seafood in the Valdez area.

ARCTIC HEALTH RESEARCH CENTER: Under the leadership of Drs. Jacob A. Brody and Robert McAlister, an Arctic Research Center Project titled "Epidemiology of Ski Injuries in the Anchorage Area" has been established in ski areas about Anchorage. The principle aim of this project, in addition to determining various aspects of the ski population, is to determine the frequency of accidents which occur and their nature, and to determine the segment of the skiing population which are at an increased risk of injury, and the conditions and equipment which predispose to injury. Apparently ski injuries have been reported to occur in up to one percent of skiers per day. Most previous studies of ski accidents have been clinically oriented and generalizations made from analysis of the population suffering accidents rather than from the population of risk. This project has received the whole-hearted support of the local skiing population. Dr. David Duncan, Greater Anchorage Health District Medical Director and an avid member of the Ski Patrol, is participating in the ski study. Through his efforts approximately 400 skiers received oral polio Type I and II at Alyeska.

Two other projects under way at Arctic Health Research Center under direction of these two physicians include a measles vaccine project study in several isolated Eskimo villages, in cooperation with the University of Washington School of Medicine, and flu vaccine study project in the student body population of West Anchorage High School. These projects should yield some very interesting and helpful clinical information to all physicians in Alaska.

UNITED STATES PUBLIC HEALTH SERVICE HOSPITALS: Kanakanak: Dr. David Dietrich ended his tour of duty in January and entered an orthopedic residency at the VA Hospital in Minneapolis, Minnesota. Dr. Ward Hurlburt plans to become an American Baptist Missionary, possibly in Thailand, when his tour of duty is completed this summer.

Dr. William Edwards, MOC at Bethel for the past two years, will enter an orthopedic residency at Duke University this summer. Dr. George Sperry, pediatrician at the Anchorage installation, participated in an international television program demonstrating the field study on measles vaccine in the isolated village of Chevak. When this program is shown on a national television hookup, a similar program in Kenya, Africa will be shown.

Dr. Robert Hampton, acting MOC at Mt. Edgecumbe since the departure of Dr. McBrayer, leaves in July for a surgical residency in San Francisco.

Both Drs. Harvey Heidinger and George Sperry added new male offspring to the booming population in March.

ALASKA MEDICINE

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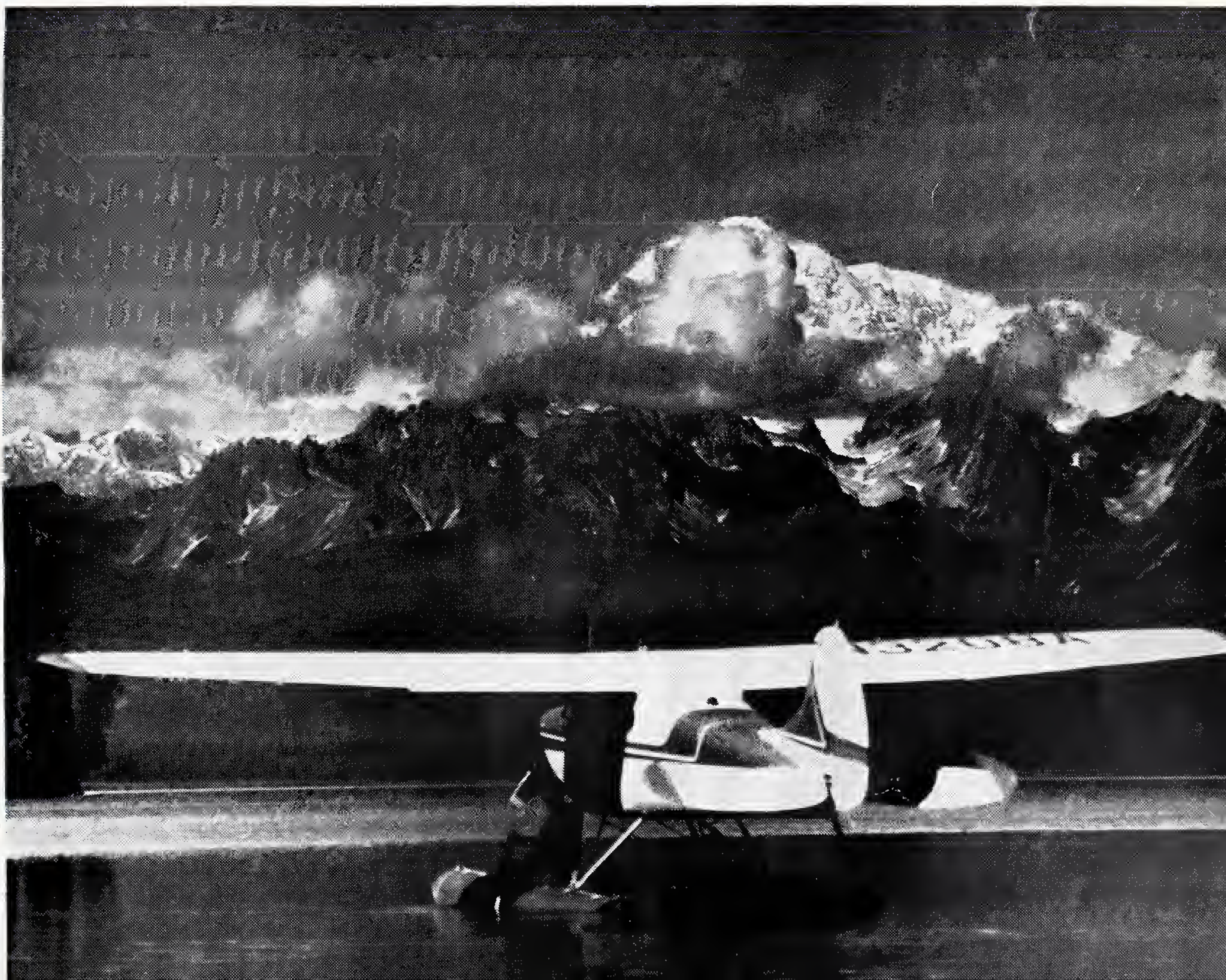

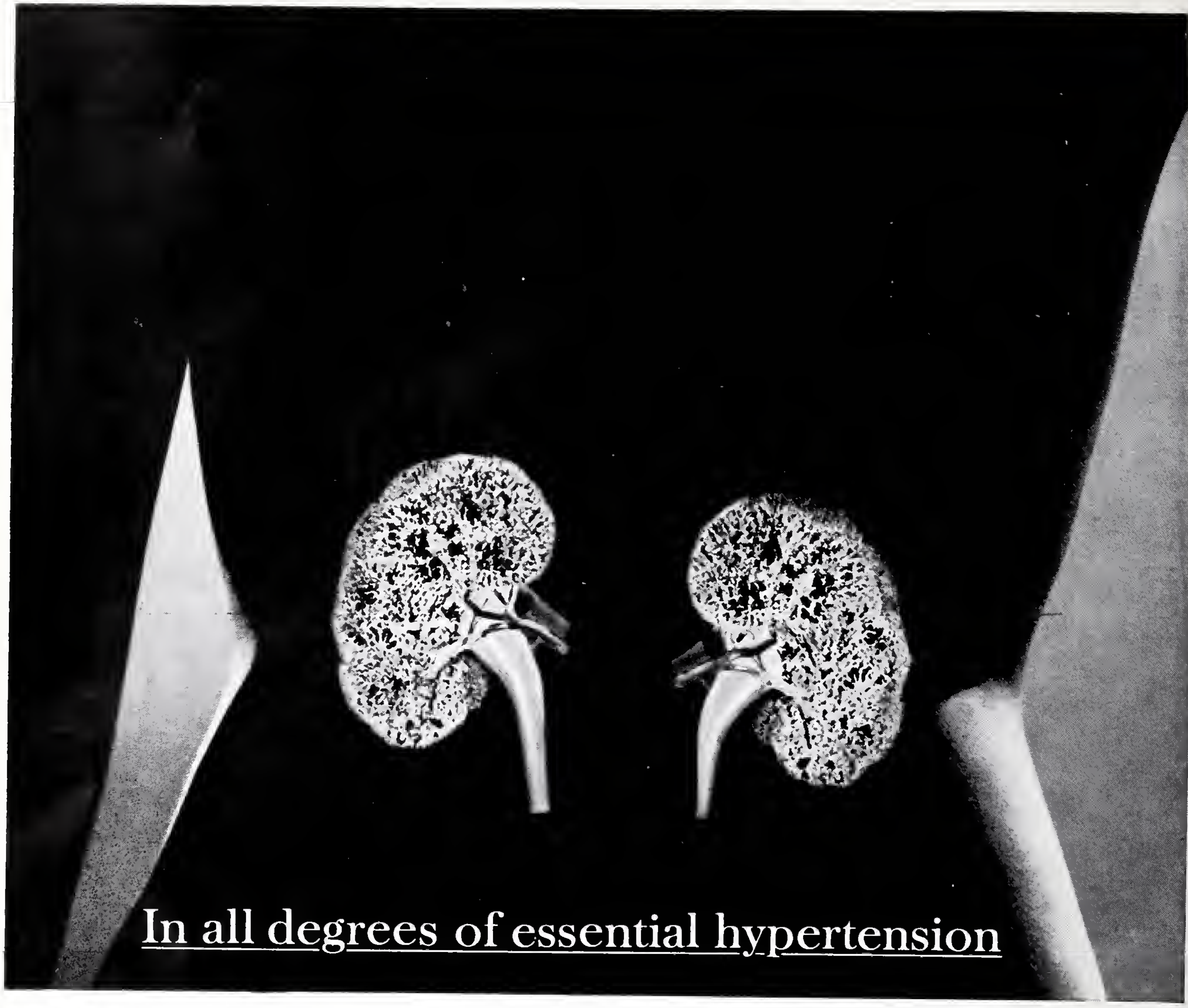
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Alaska Medicine

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TUBERCULOSIS OF BONES AND JOINTS

*CARROLL B. LARSON, M.D.**

Presented at the 18th Annual Meeting of the
Alaska State Medical Society
Sponsored by The Alaska Tuberculosis Association

In the late 1800's Hugh Owen Thomas invented the Thomas splint for the treatment of tuberculosis of the hip. His idea was a departure from the accepted Rollier Clinic therapy in Switzerland which consists of bed rest, good food and sunshine. Thomas added the new thought that mild immobilization of the diseased part, namely knee and hip, was beneficial in addition to bed rest and sunshine. It provided also a means for prevention of severe contractures of the joints. This marked the birth of the orthopedic management of bone and joint tuberculosis.

The early Orthopedic hospitals in the U.S. such as "The Hospital for the Ruptured and Crippled" in New York and the Children's Hospital in Boston cared for tuberculosis of the skeletal system and these cases made up as much as 80% of the hospital census. Convalescent homes sprang up to unload the hospital of the chronic care and modalities of treatment such as the Bradford frame, plaster beds, traction and open air pavilion therapy prevailed here and abroad. Public Health activated a program of case finding, and case isolation which demanded many additional hospital beds so during the early 1900's many states built tuberculosis sanataria to take care of the excess numbers.

Sporadic attempts at surgical extirpation of tuberculosis of bones and joints were made beginning with Kocker and others. These were unsuccessful because of lack of aseptic techniques, absence of parenteral replacement therapy and technical inability to circumvent the diseased areas. By the late 1930's when transfusions became available, anesthesia better controlled, and asepsis an established technique renewed surgical attacks on tuberculosis occurred. However, because of an ingrained philosophy of conservation based on past experiences these new attacks by surgeons made very little inroad except in the area of joint fusions. Fusions were popular and dispute remained only in the realm of technique. Each surgeon felt he could gain secure fusion better by his technique than others; hence standardization of techique even to this day has not occurred. Albee fusion of the spine and Trumbull fusion of the hip were most common but by no means universally adopted. The concept of putting the joint to rest by fusion, regardless of technique was highly accepted however and only a few renegade surgeons persisted in attempts to excise disease.

Bone and joint involvement by tuberculosis with concomitant persistent sinuses, secondary infections, abscesses, sequestra and deformities remained commonplace although decreasing in numbers as a result of public health measures to control dissemination of tuberculosis such as testing of milk sources, isolation of carriers and improved general sanitation.

The breakthrough in the management of tuberculosis generally was ushered in by the advent of antibiotics streptomycin, INH, PAS. In a space of ten years trials of these drugs many new approaches became available and old concepts challenged. Accumulaive experience with bone and joint tuberculosis was more or less summarized in Orthopedics and is available for reading in the Journal of Bone and Joint Surgery of 1948. The concensus in general is that the antibiotics have appreciably reduced mortality by prevention of generalized spread of the disease from any one focus; that localization of the disease has been enhanced; and that surgical attack on the local lesion is feasible and necessary for the drainage of abscess, removal of sequestra and for correction of deformity.

The concept of absolute immobilization by fusion has given way to sophisticated attempts at excision of disease. Fusions are not relegated to those cases where excision leaves a joint unfit for reconstruction or to the cases where collapse of a vertebral body or bodies renders the spinal column particularly susceptible to gravitational postural strains.

---

* Professor and Head of Department of Orthopedic Surgery, State University of Iowa, Iowa City, Iowa

The areas that remain important to us as physicians are the early detection of cases; accurate verification of diagnosis; early institution of antibiotic therapy; and prevention, recognition, and treatment of complications such as abscess dissemination into other areas and sequestration of necrotic tissue.

To help us in the early recognition and resolution of tuberculosis certain guides must be kept in mind:

1. Awareness of possibility of tuberculosis as the etiology of any painful joint or backache. A few questions in history can lend support if the milk supply is unpasteurized or other persons in the family have known tuberculosis. An x-ray is mandatory to note local bone atrophy, destructive focus or joint narrowing. A tuberculin test in high dilution is meaningful if positive, especially in children. Joint fluid if available will show diminished sugar level of 50% compared with simultaneous blood serum level. Guinea pig innoculation or smear identification of tubercle bacillus is the only final clincher.

2. Awareness of the associated lesions of tuberculosis. Joint or bone involvement is almost always blood borne from another focus, usually chest. Chest plate will show active tuberculosis in 20% of proven cases of joint tuberculosis. 90% of remainder of cases will show some other evidence such as a Ghon complex or old calcified healed lesions. If tuberculosis is seriously under consideration the kidneys should be x-rayed and often individually catheterized for detection of bacilli.

3. Joint involvement is secondary to bone. Unfortunately the beginning of caseation in bone may be much delayed in changing the shadow of bone which we see in x-ray. The protective reaction in joint fluid and synovitis may be an early response to the bone involvement and with x-rays negative one would be inclined to think of primary synovial tuberculosis. In looking over pathological material I have been unable to find any case of suspected joint tuberculosis where a bony involvement could not be demonstrated. If this be so one should continue the search for the bony focus and eliminate it surgically as soon as demonstrated considering it the source of the joint involvement.

4. Initial treatment should be conservative with antibiotics. The part involved should be rested but not necessarily immobilized. Removal of weight bearing or gravity or both is necessary. This promotes body well being which in turn improves body natural defenses, and this coupled with antibiotics gives best opportunity to keep disease local, control local progression, and in fact promote healing.

5. Application of surgical therapy. This is indicated when the general response shows the disease to be controlled—which is to say, improved appetite, weight gain, normal temperature and stable local signs. Usually two to three months of antibiotics will provide this stabilized period. At this point careful interpretation of local signs and x-rays may show presence of abscess, persistence of sequestra or localization of bone focus. Any of these should be dealt with by surgery if the disease is to be eradicated. The decision for surgery and the type of surgery will be based on the judgment and experience of the orthopedic surgeon at the time.

6. Continuance of antibiotics. With or without surgical therapy the antibiotics should be continued for long periods. Accumulated evidence points to a minimal period of a year and perhaps up to two years if incomplete healing is evident. Streptomycin plus PAS are probably most effective early in the first two to three months to bring the disease under control and for three to six months after any surgery. INH can perhaps maintain the disease control through the next year of healing time and is more easily administered. The dosages at average recommended levels are safer and probably as effective as large doses. The complication of hearing loss from streptomycin should be kept in mind and mild psychoses can accompany INH. If either occur they can be controlled by omitting the drug or drastically reducing the dosage.

PEPTIC ULCER AND THE SUPERIOR MESENTERIC ARTERY SYNDROME

THEODORE SHOHL, M.D.
ANCHORAGE, ALASKA

Presented at the
18TH ANNUAL CONVENTION
of the
ALASKA STATE MEDICAL ASSOCIATION
ANCHORAGE, ALASKA
JUNE 1, 1963

Dr. Shohl

The condition of obstruction of the duodenum by the superior mesenteric artery was first described by Rokitansky[3] in 1849 and has been rediscovered and described repeatedly[1-4-5] since that time. In spite of the well-documented studies of this condition, however it is often not considered in the differential diagnosis of upper gastrointestinal disease.

The association of peptic ulcer with this condition was also recognized as long as fifty years ago and may occur in as many as one fourth of the patients having partial obstruction of the distal duodenum.[6] This association is readily accounted for as recent knowledge of the physiology of gastric secretion has been accumulated. The prolonged stasis of food and secretions in the stomach which is well demonstrated at fluoroscopy of pattients with this condition acts as a strong stimulus for the secretion of gastrin by the gastric antrum. This in turn stimulates the secretion of the gastric acid, pepsin and fluid by the gastric fundus, further gastric retention, and a vicious circle is established, resulting in the development of a peptic ulcer.

These ulcers may be markedly unresponsive to the usual medical therapy unless the underlying condition is recognized and corrected. The surgical treatment of the combined ulcer-mesenteric obstruction syndrome presents several interesting problems which it is the purpose of this paper to explore.

The cause of mesenteric artery obstruction is primarily related to anatomy and posture. Incomplete rotation of the colon, lordosis and the structure of the mesenteric attachment at the ligament of Treitz are contributing factors. The condition is usually seen in people of asthenic and ectomorphic habitus and visceroptosis or "tired organ" syndrome. Obstruction is much more pronounced when the patient is in the supine position and may be markedly relieved when the prone or "all fours" position is assumed. This can readily be demonstrated by intestinal fluoroscopy.

Symptoms are often present for many years with gradual progression, dating back to childhood in many cases. They consist of epigastric fullness, bloating and pain, usually occuring immediately after eating. Vomiting is frequent and material ingested many hours previously may be identified. In the absence of peptic ulcer response to antacids is not striking. Relief of symptoms in the prone or lateral decubitis position is common and may lead to the erroneous diagnosis of hiatus hernia. The prolonged disorder often results in malnutrition and personality disorders. Constipation is common. Acute complete obstruction may suddenly develop.

Diagnosis involves primarily consideration of the condition in the differential diagnosis and demonstration of the obstruction by the alert or alerted radiologist. The roentgen findings consist of marked dilatation of the duodenum with a sharp line of termination at the position of the artery. Prominence of rugal folds and reverse peristalsis may be observed in the duodenum. These findings may disappear with assumption of the "all fours" position. Prolonged gastric emptying is the rule. Measurements of gastric acidity have not been of value due to contamination of the gastric aspiration by regurgitated bile.

Treatment of duodenal obstruction when not complicated by ulcer may be medical or surgical. Medical measures are directed primarily at improving the nutritional status. To this end high caloric high vitamin meals in frequent small feedings are prescribed. An abdominal binder is worn when the patient is erect. Assumption of the prone position is advised postprandially. Laxatives are prescribed if indicated. In more acute cases gastric drainage and electrolyte correction may be required.

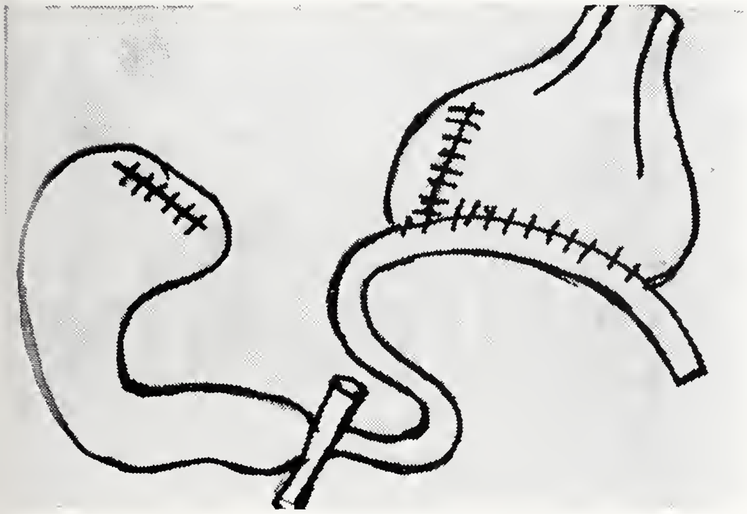

Figure 1

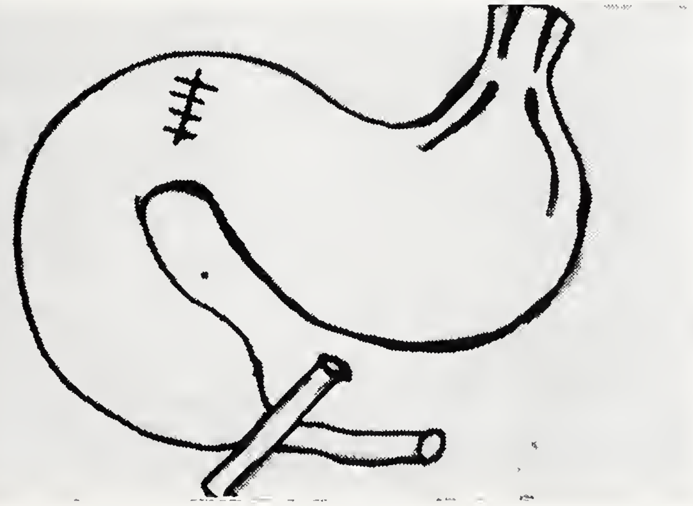

Figure 2

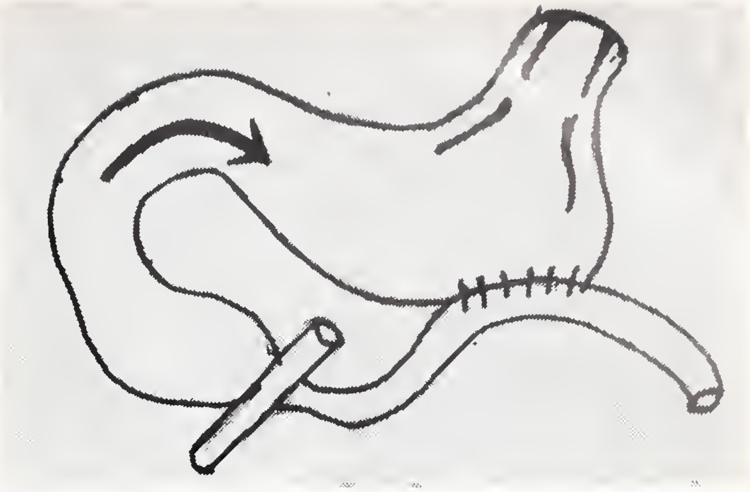

Figure 3

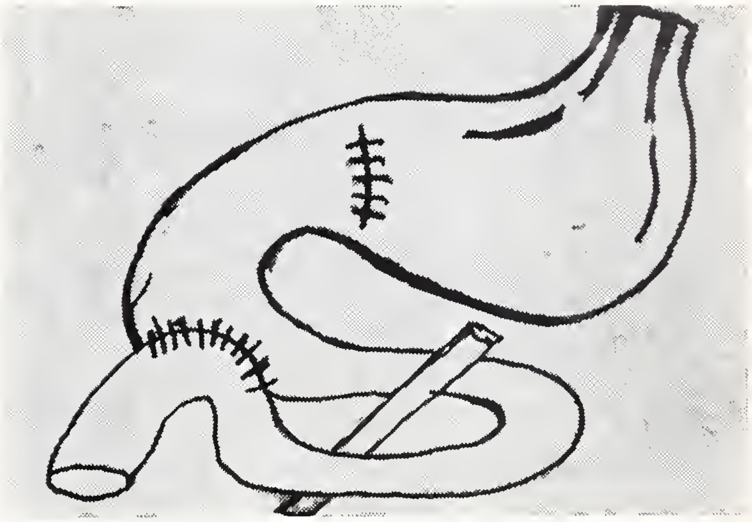

Figure 4

Surgical treatment is indicated in patients who do not respond to medical treatment. The standard operation for many years in cases uncomplicated by ulcer has been duodenojejunostomy. This provides a bypass of the obstruction without retrograde flow into the stomach and has given vastly better results than gastroenterostomy. Strong in 1958[4] advocated direct attack on the mesenteric structures and division of the ligament of Treitz at the fourth portion of the duodenum. He reported a good result, but wide experience with this technique has not yet been reported.

When the presence of peptic ulcer complicates the picture the surgical procedure is far more complex. Standard gastric resection with either Billroth I or II reconstruction is not satisfactory, for in a Billroth I the duodenum is still obstructed by the artery and in a Billroth II the bile and pancreatic juice enter a pouch of duodenum obstructed by the artery at one and the duodenal closure at the other. (Fig. 1) This carries the additional risk of leakage of the duodenal stump with ex-

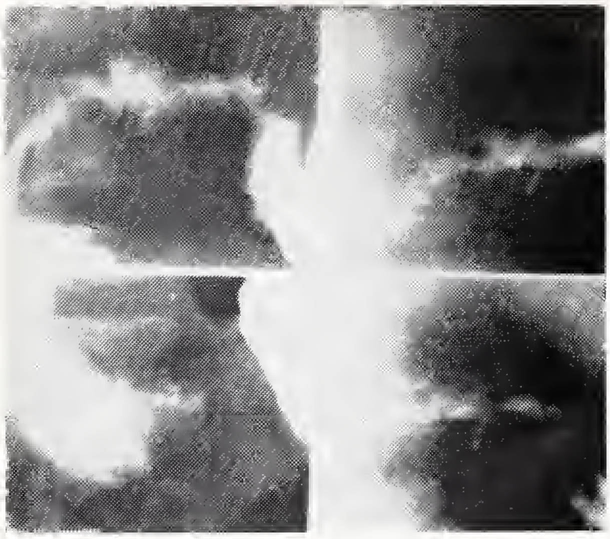

Figure 5

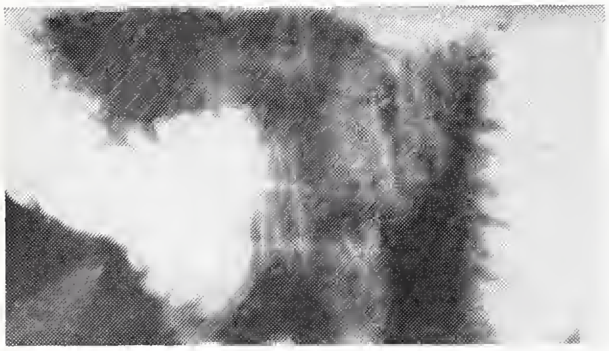

Figure 6

tensive inflammation and fibrosis. Vagotomy and pyloroplasty (Fig. 2) does not overcome the arterial obstruction, and vagotomy with gastroenterostomy (Fig. 3) requires regurgitation of bile and pancreatic juice into the stomach before final drainage through the gastroenterostomy. The solution of the problem lies in the addition of duodeno-jejunostomy to one of the standard ulcer operations, as shown in Figure 4. The simplest, safest and probably the best arrangement is vagotomy, pyloroplasty and duodenojejunostomy, which controls the acid production and provides adequate drainage without devascularizing the duodenum by extensive mobilization and without regurgitation of bile and pancreatic juice into the stomach.

These points are illustrated by the following case report. The patient was seen at age 38. He had had severe recurrent abdominal pain since age 15, when he was told he had an ulcer. At age 24, he had a perforation of a duodenal ulcer which was closed surgically. Since that time, he had had frequent epigastric pain radiating to the back and was chronically constipated. X-ray examination showed severe scarring of the duodenum and the typical X-ray of the superior mesenteric artery syndrome, Figures 5 and 6. At operation a vagotomy and gastroenterostomy was done.

His post operative course was marked by gastric retention and at first by poor function of the gastroenterostomy, requiring prolonged nasogastric drainage. After one month the gastroenterostomy function improved and the patient when seen a year later has gained ten pounds and was completely relieved of abdominal pain. He still had an occasional feeling of fullness. The addition of duodenojejunostomy would probably have prevented his difficult post operative course and provided complete symptomatic relief.

Summary: 1. The superior mesenteric artery syndrome is an established clinical entity with characteristic clinical and X-ray findings.

2. Peptic ulcer complicates the syndrome in about one fourth of the cases, probably on the basis of gastric retention and gastrin induced secretion of acid.

3. Treatment of the uncomplicated syndrome is first of all medical and may be quite satisfactory.

4. Medical failures, if no ulcer is present, may be treated by duodenojejunostomy with confidence of success. The division of the ligament of Treitz, while a direct and presumably satisfactory procedure, has not yet had wide clinical trial.

5. The complication of peptic ulcer makes the medical treatment unsatisfactory and requires the correction of hypersecretion of acid and duodenal drainage procedure. The suggested procedure of choice is vagotomy, pyloroplasty and duodenojejunostomy.

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WEBBED FINGERS AND TOES

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of the
ALASKA STATE MEDICAL ASSOCIATION

ANCHORAGE, ALASKA
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Dr. Kettelkamp

Webbing of the finger or toes is called syndactylism. Syndactylism is present in a number of animals including some of the gibbons and gorillas, kangeroos and other marsupials. In man syndactyly occurs once in two to three thousand births. [5 13]

Syndactyly occurs as a developmental defect or as an inherited characteristic. In the human embryo the hand is an undifferentiated disc at four weeks. At five weeks the finger rays are present as rods of condensation with scallops marking the ends of the digits. In the six week embryo there are slight finger projections with dorsal grooves between the digits which are still webbed. At seven weeks the fingers grow rapidly so that the webbing is obliterated. Jointed cavities and ossification centers appear during the third month. Arrested development in the seventh or eighth weeks results in syndactylism.[2] A family history of syndactyly is present in eighteen to forty per cent of the cases.[11 13] Study of these families has shown that syndactylism can be transmitted according to Mendelian inheritance.[2] Syndactyly is more common in males and may be transmitted as a sex linked characteristic. Inherited syndactylism is more likely to be in the simpler form.

Syndactylies are classified as simple when the web contains only soft tissue and complicated when the adjacent phalanges are fused or when there is interposition of accessory phalanges. In complete syndactyly the web extends to the ends of the fingers. It is incomplete when it does not. Syndactylism may involve one or more appendages. There has been bilateral hand involvement in forty to fifty-two per cent of the cases reported. [11 12 13] When only one hand is involved it is most often the left.[11] The fingers are not involved with equal frequency. In sixty-nine syndactylies reported the middle and ring fingers were involved in fifty per cent, the little and ring fingers in twenty-eight per cent, and the middle and index fingers in fifteen per cent. [11] Usually the web involves only two fingers. The thumb is rarely involved except in the mitten hand when all fingers are involved.

Associated congenital anamolies are common in patients with syndactyly. Additional anomalies of the hands, particularly brachydactyly and hypoplasia of the digits are common. Congenital anomalies other than those of the hand and feet are also common and must be looked for. [11 12]

The goal in syndactyly repair is to produce a commissure between the involved fingers which is supple, to cover the adjacent sides of the involved finger with supple skin which does not limit their motion, and to produce a commissure and fingers which are cosmetically similar to normal. There have been many procedures devised to obtain these goals. A brief historical review will serve to emphasize the principles of surgical repair.

Rudtorffer in 1801 made a tunnel from the dorsal to the volar surface at the site of the commissure through which a leadened wire was placed and retained until the tunnel epithelialized. The remainder of the web was then severed between clamps. Excessive scarring and contractures resulted.[14] Zeller in 1810 introduced the use of a dorsal V-shaped flap to form a commissure. The fingers were separated by a longitudinal incision. A better commissure was thus formed.[15] Didot and Diday in 1850 and Nelaton in 1884 described similar procedures which utilized narrow rectangular flaps to cover the fingers. This was the first precedure in which flaps were used for this support.[8] It was unsatisfactory because there was still insufficient skin to cover the fingers without tension, linear scars resulted and no commissure was provided. Davis and German in 1930 described the use of skin graft to cover the fingers.[8] Kanavel reported a modification of this procedure in 1932.[10] Davis and German also reported a second procedure using two triangular flaps to form a commissure and skin grafts to the fingers.[8] This procedure was illustrated by Bunnel in 1932.[4-5] Linear scars and contractures often resulted from these procedures; however, the addition of the skin graft was an important contribution. Cronin in 1943 recommended separating the fingers with zig zag incisions to prevent linear scarring.[6-7] Barsky in 1951 also advocated this. One of two triangular flaps were used to form the commissure. Bauer, Tondra and Trusler in 1956 used a similar procedure with a rectangular flap to form a commissure.[3] This flap was modified slightly by Flatt to decrease the risk of sluff.[9]

The basic principles of the surgical repair of syndactylism are a commissure formed by flaps, the fingers separated by zig zag incisions to avoid linear scars and contractures, and the use of skin grafts to provide the additional skin needed. The repair is often complicated by anomalies of the digital arteries and nerves and anomalies of the tendons, bones and joints. When there is a synactyly on each side of a finger both should not be repaired at the same time. The results of syndactyly repair in the hand are better if the child is over a year and a half at the time the procedure is performed.[11] When the syndactyly is complicated by fused phalanges or rotational deformity it is often desirable to separate the fingers as an initial procedure at an earlier age. A definitive syndactyly repair is then completed at a later date.

Fortunately, webbing of the toes presents much less of a problem. Independent toe motion is not necessary for good function. Syndactyly repair of the toes is largely cosmetic and is not as critical as in the hand. The basic procedures are similar to those described for the hand. The operation can wait until the child is five years or older at which time it is less difficult to perform. Complete syndactyly of the toes only rarely will require treatment.

SUMMARY

Syndactylism of the hands and toes is one of the most common congenital anomalies. It may occur as a developmental defect or as an inherited characteristic. There are frequently associated congenital anomalies. The principles of syndactyly repair involve the use of zig zag incisions to separate fingers, flaps to form the commissures and skin grafts to cover the remaining denuded areas. This procedure should not be performed on children under a year and a half of age.

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EIGHT POINTS TO PURGE FEDICARE

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Delivered before the Alaska State Medical Association, Anchorage, Alaska, June 1, 963

I trust you won't think me out of order to mention the State of Texas right here at the beginning. But this fellow from Texas was talking to me recently and I noticed that he was quite alarmed. Did you know," he said with some excitement, "there is a movement afoot to divide the State of Alaska in two?"

"No," I said, "I didn't know that."

"Well, it's true," he told me, "and, by gosh, I'm fighting it. I'm not about to sit still while some guys go out and make Texas into the third largest state in the Union!"

Well, there might be a little exaggeration somewhere in this story, but I can honestly say that my visit to your great state—my initial visit, I might add—has been most breath-taking. It is a real pleasure for me to come up here from Ole Rebel country to see your vast and vigorous state. And it is a pleasure for me to be with you today, to talk to you, my colleagues in the new frontier of America.

Of course, I realize I might have chosen a better expression to use than "new frontier." But it does give me a convenient bridge to jump right into what I want to talk to you about this evening. It gives me the opportunity to tell you the story of Fedicare, the political hoax that the new frontiersmen on the Washington scene are trying to pass on onto the American people.

For several years past the most important and, at the same time, perhaps, the most controversial question facing American society, is the question of financing medical care for the aged. It is an issue in which not only every occupational and age segment of the American public is concerned, but it also is one in which every individual physician in our country is vitally and personally involved, both as civic-minded citizens and as members of the profession which would provide the medical care needed.

And I might add that there are two other good reasons for our feeling of vital concern. First, and perhaps this is ironic, we are the profession most responsible for the increase in longevity now enjoyed by Americans. This is the boom which, according to the new frontiersmen, has created a problem for the large group of more than 17½ million Americans over the age of 65 living in our nation today.

Second, maintenance of the quality of American medicine at its present zenith, unequaled ever before in history, is a responsibility which the doctors of our country are proud to bear. Yes, we are proud of the calibre of American medicine today, and we gladly assume the responsibility to see that it is made available to all Americans, regardless of age.

Over and above that, we feel that the quality of the medicine we practice today came to us only through hard work—hard work performed under the impetus of and in the free and unfettered air of a system of private enterprise. None of the miracles of modern medicine would have been possible with a socialistic approach.

The physicians of America realized these things early, and so we were armed with courage, righteousness, and the confidence of success when we beat back the threat of the Murray-Wagner-Dingell Bill in 1949 through 1952, again when we battled the Forand Bill which first came up in 1957, and then once more against the King-Anderson Bills of the last few years. We knew then, as we know now, that the socialists' approach to providing medical attention for a segment of our population is not the proper way to do it, and the people of this country—once they saw behind the propaganda and the falsely emotional appeals cloaked in humanitarianism—were wise enough to reject these proposals.

They were wise enough to see the beginnings of socialized medicine, the setting of the stage for the decline of quality medical care. And they were wise enough not to want our nation to take its first step backwards in regard to medicine.

But the fight is still flaming, and it is imperative that we keep the American people informed and aware, so that they will not heed the Lorelei blandishments of the artful propagandists, the vote-hungry politicians.

The 1963 model of the King-Anderson Bill—because Americans properly rejected earlier editions—has been given a different grill and some fresh chrome work here and there. It is an obvious bid to attract new buyers in the current legislative market.

But make no mistake about it; the 1963 King-Anderson Bill is the same intense, hard sell of federally-controlled medical care that was characteristic of previous bills.

The new Bill provides, as did last year's model, for substituting compulsion for free choice in financing health care. It maintains a pretense of solving the medical care needs of the aged, when in fact, it offers only limited hospital or nursing home care. It would cover only a small portion of any elderly person's total medical bills. It would clear the way for federal officials and employees in Washington, untrained in medicine, to set up their controls and begin to fasten their grip on hospitals and physicians in this country for the first time in history.

I realize full well that this is a most serious charge. But I have grown up and matured professionally in a science and art that has flourished in freedom, can only flourish further in the atmosphere of freedom, and at this point in history—when medicine is on the threshold of its golden age because of its spectacular growth under this system—I cannot do otherwise but to spotlight this enormous challenge that threatens medicine's continued and healthy growth.

So I make this charge that King-Anderson is federal control of medicine. And, moreover, my charge is a thoroughly truthful one and it is based on facts.

Where are the controls? How would they work? What is the system the Washington social planners have devised this time?

Under the bill, hospitals and nursing homes would be required to have "utilization review" plans as a condition for participating in the federal payments. Necessarily, these would function to the satisfaction of the Secretary of the Department of Health, Education, and Welfare who controls the funds for the care of the elderly. The "plan" in each institution would be carried out by a hospital staff committee composed of two or more physicians and it could include other professional personnel. Or it could be a group outside the hospital which is similarly composed.

The committee would be empowered to clear the admission of aged patients and their lengths of stay in the hospital or nursing home. The groups also would be required to review the "medical necessity" of the service performed in the institution at government expense. So there is no other way to read the bill: The Judgment of a patient's own physician could be vetoed by the bureaucratic machinery. There would be a third party intervening in the normal doctor-patient relationship.

More specifically, the "utilization review" committee would be required by the bill to review each patient's case after the 21st day to determine the "medical necessity" of a further stay in a hospital or nursing home. Thus the committee—and not the patient's physician—could decide when an individual's hospitalization under the program would be terminated.

Does this sound like intervention in the affairs of a patient and his physician? Does it sound like control?

There should be no misunderstanding on this point. There can be no doubt that the "utilization committee" must perform to the satisfaction of the HEW secretary who controls the funds for the program, and the primary reason for requiring such reviews of cases is to control the expenditure of funds. We must remember that supervision and control—the regulation by government agencies—always lies at the heart of all federal aid programs. Once accepted, once a dependency has been created, the recipient has no alternatives but to accept increasingly stringent requirements—requirements as to control—as a condition for continued government support.

So this is a specific taste of what King-Anderson has in store for us, if we allow it to become the law of our land. There is much, much more. I urge you to obtain a copy of the bill so that you can study it and know it thoroughly.

Now, let me outline an 8 point general campaign and program of action which we can all follow or subscribe to:

First, insist that the truth be told.

In a task force report to President Kennedy in December, 1960, Wilbur Cohen, the Assistant

Secretary of HEW for Legislative Liaison said of the King-Anderson Bill: "This system permits people to contribute during their working years to the relatively heavy costs of medical care in their later years."

This theme that the social security medical care bill actually does permit people to contribute during their working years to pay the costs of their own medical care when they retire is the theme that has been used most often by proponents, even by the President in his recent message to the Congress, and by Secretary Celebrezze in recent pronouncements. Now the fact is that these words do not represent the proposal. Let's take a look at that Wilbur Cohen sentence. He says, "this system permits people to contribute." In fact, of course, the program would compel people to pay an additional payroll tax; it does not permit contributions. He says that these "contributions" are paid during a person's working years for the purpose of paying one's own health care costs in the future; this is false. Not one penny of today's taxes under the proposed health care bill would be set aside for the prepayment of one's own health care costs in the future. All of the taxes raised under these bills would pay for the benefits provided to today's aged beneficiaries. Tomorrow's health care benefits would be financed through additional payroll taxes on tomorrow's young workers and their employers.

Second, know the issues.

You cannot tell our story and be persuasive unless you know the basic issues involved in this controversy. Let's take a look at them.

(a) **Compulsion.** This program is **compulsory.** It does not provide for a voluntary selection of the mechanism of financing our own health care. It compels people to participate in a tax program so that the federal government can purchase health care as provided in the bill.

(b) **Help for the Needy vs. Help for Everybody.** The issue is help for those persons over 65 who are needy, or near needy vs. help for those persons over 65 who are solvent, self-reliant, able to take care of themselves. We support legislation and programs designed to meet the need of those persons over 65 who are not in a position to take care of themselves.

(c) **The Economic Status of the Aged.** The Administration has promoted this program on the premise that practically all persons over 65 are so economically impoverished that they cannot afford to take care of themselves. What are the facts regarding the economic status of the aged? Persons over 65 are improving their economic status even more rapidly than all other age groups. Here are just a few statistics from the Department of HEW, itself, from the Federal Reserve Board and from other sources of information. The median total value of the assets held by families whose head is over 65 was $8,349 in 1960, almost twice as high as the $4,839 which was the median value of the total assets of all other age groups. The median value of liquid assets of families with a head over 65 was almost two and a half times as great as compared with the liquid assets of all other families.

On home ownership, a larger proportion of the aged families 64% were home owners than younger families 54%, and of the over 65 families, 53% owned their homes free of mortgage as contrasted with only 18% of all other families. The aged are substantially better off than younger families on indebtedness, with 74% of aged families owing no personal debt whatever compared with 34% of younger families in this position.

Persons over 65 as a group are improving their economic status more rapidly than any other age group because of the fact that the new entrants coming into the group have far more life insurance, savings, annuities and pensions, special tax deductions and credits than the group over 65, from 75 to 80.

These opportunities for additional saving, life insurance accumulation, participation in private pension plans and the freedom from prolonged depressed economic periods, such as the older group experienced, have provided an economic situation for our 17½ million persons over 65 that, in fact, is reducing their dependence on other persons and on any level of government for support.

(d) **Voluntary Enterprise vs. Government Intervention.** The Administration's program in effect says that voluntary enterprise for persons over 65, needy and non-needy, has failed—that the Blue Cross-Blue Shield plans and health insurance industry have failed. Therefore, the Administration argues, the federal government must intervene. This is false. The opposite is true. Voluntary enterprise via health insurance policies, the Blue Shield, Blue Cross, and other voluntary approaches have markedly improved the ability of the aged to take care of themselves. Two statistics are particularly pertinent in this respect. In 1952, 22% of all persons over 65 were on public assistance; today only 13% of all persons over 65 are on public assistance. There has been a steady decline in the percentage of persons over 65 who have needed public funds for health care. One other statistic is particularly significant. In 1952 only 28% of all persons over 65 had voluntary health insurance coverage of any type. Today that figure is over 55% and rapidly increasing. This increase of more than 100% in 10 years in the purchase of health insurance of various types by persons over 65 is a phenomenal example of successful voluntary enterprise.

(e) **The Inequity of the Tax Burden on the Young**. This bill places a tremendous tax burden on our children and grandchildren of the future. Senator Kerr, in the Senate debate in July 1962 when the Anderson-Javits bills were being considered, pointed out that the Department of HEW had informed him that it would cost at least thirty-five billions of dollars during the lifetime of today's eligible beneficiaries over 65 to provide their benefits. These thirty-five billions of dollars would have to be raised by heavy payroll taxes on the young workers of the nation.

Third, tell our story.

This is the key element of our campaign. If we tell our story, tell it well, articulately, persuasively, temperately, and repeatedly on TV, radio, through speakers bureaus, through letters to the editor, through coffee klatsches, and through physicians' offices, then we shall win our campaign. The Gallup Poll, for example, in December, 1961 showed that approximately 67% of the American people favored some health care program via social security. But in February, 1963, this percentage had dropped to 55, in May it had dropped to 48, and later, after the Madison Square Garden addresses of President Kennedy and Doctor Annis, the percentage of support dropped to 44%. The fact is that there is no evidence of an over-whelming sentiment for or against this proposal.

Our job is to continue to tell our story so that the percentage of support continues to drop. AMA will do its part, but the major responsibility in the final analysis must rest with every state and county medical society, with the physicians themselves and their wives to tell the story effectively.

Fourth, the Kerr-Mills Act.

The next point in our over-all program is the Kerr-Mills program and its rapid implementation. The American Medical Association has strongly supported a federal-state grant-in-aid type of program to provide health care to persons over 65 who need help. We supported the Kerr-Mills bills when they were first proposed and the Congress, by a large majority, adopted them. We have since worked closely with the state societies and other organizations to implement the Kerr-Mills Act as rapidly as possible. The fact is that this Act is being implemented by the states at an accelerating rate. In recent months the number of persons who have received benefits under this Act have increased markedly.

Fifth, voluntary health insurance prepayment plans.

We must continue to promote voluntary health insurance and Blue Shield-Blue Cross plans to provide ever better opportunities for the purchase of adequate financing mechanisms—health insurance policies and prepayment plans tailored to meet the needs of older persons. A wide variety of voluntary health insurance policies especially designed for older people has become available during the last two years.

Sixth, allies.

Medicine cannot win this fight alone. We must win in concert with all those organizations and individuals who think as we do. These allies include not only the NAM, the U.S. Chamber of Commerce, the health insurance industry and prepayment plans, and the American Farm Bureau Federation, but also hundreds of other groups, national and local. We should do everything possible to communicate our thinking to them and to work with them to formulate policies along the same line.

Seventh facilities.

New facilities for the care of older people are badly needed. A long-term chronic patient over 65 is especially in need of those facilities which provide adequate long-term institutional care of the skilled nursing home type at a rate that is reasonable. The American Medical Association has worked with other organizations, including the American Hospital Association and the American Nursing Home Association, to speed up the expansion of our skilled nursing home system, both of the non-profit and of the proprietary type, and we are now promoting programs designed to raise the standards of these institutions at the most rapid rate possible.

Eighth, positive program for the aged.

What are we for? Basically, we're for help to those who need help, including Kerr-Mills and similar types of programs, and for voluntary enterprise for those persons over 65 who are solvent and can take care of themselves. We're for a new attitude toward the aging, an attitude which permits them to become part of the mainstream of our society, that does not segregate them out from all other age groups. We're for flexible retirement rather than compulsory retirement at the age of 65 in order to stimulate increased productivity and self-reliance. We urge special emphasis on the prevention of mental illness among the aged because so many aged persons now reside in mental hospitals mainly for domicilary reasons and not because they are mentally ill. Long-time enforced idleness and loneliness finds them in their later years in mental institutions where they don't belong.

Here are some of the favorable factors that should permit us to end the year 1964 as a profession that is still free, as a nation which still relies on voluntary enterprise, on voluntarism rather on compulsion, to finance the health care of our people. First, the favorable factor of a rapidly improving economic status of the aged. Second, the rapid implementation of the Kerr-Mills programs throughout the nation. Third, the fact that the nation has just been exposed to a social security tax increase in 1963 of 2.2 billion dollars. The climate now is not ripe for a program which promises to increase payroll taxes on both employers and employees, approximately $2 billion at its inception in 1965 and, certainly, at a much higher level in subsequent years. These are the years for tax reductions, not for tax increases.

We do, however, have unfavorable factors which militate against us. One is the continuing popularity of the President himself and the obvious profound power of the White House and of the Executive Department. Secondly, perhaps the strongest unfavorable factor that continues to be operative is the AFL-CIO and its political arm COPE. Labor has improved its effectiveness in recent years and will undoubtedly utilize its full power through many labor affiliated organizations to press for enactment of this bill.

But, the most unfavorable factor of all perhaps is ourselves.

In a comic strip recently, Pogo said, "We have met the enemy and he is us." Fatigue, compromise, yielding to the false doctrine of inevitability, defeatism are our principal hazards. Our basic position is sound if we keep up our courage, if we believe in victory rather than in defeat, if we don't yield to compromises which in effect undermine our entire position. If we tell our story effectively, we shall win.

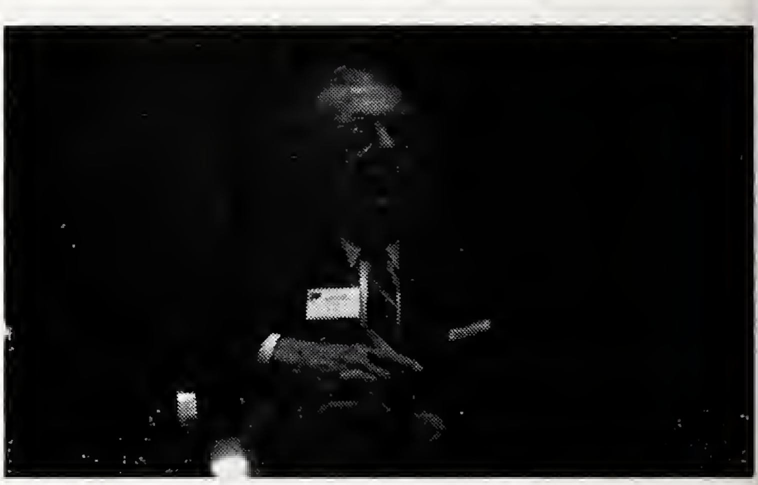
Convention

Dr. Mills Addresses Meeting

Legislative Council Hears Dr. Crawford

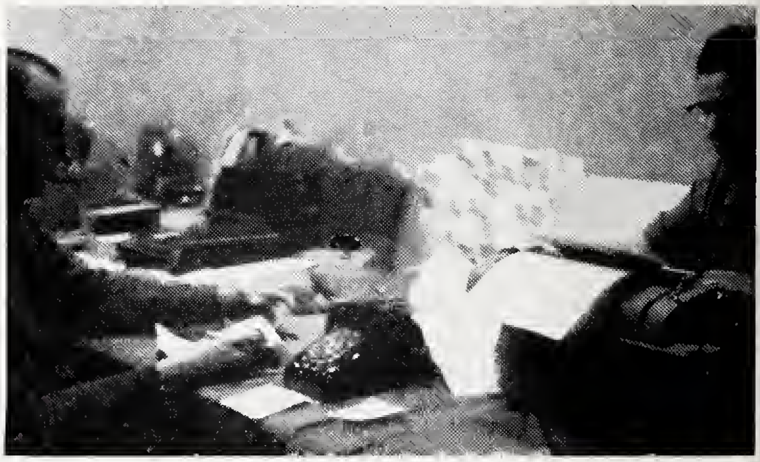
Dr. Warren Speaks at Heart Banquet

Agency Panel in Session



A.M.A. Vice-President Dr. J. P. Culpepper

Anchorage Medical Society Cocktail Party



Secretaries at Work

ALASKA STATE

Anchorage

Highlights

A.S.M.A. President Dr. Ralph Carr

Exhibit Hall

Mesdames Phillips, Carr, and Cates

MEDICAL ASSOCIATION

May 29 - June 1, 1963

Dr. Langston addresses A.M.P.A.C. Breakfast

A.A.G.P. Luncheon Meeting

Mrs. Thuss Speaks at Auxiliary Luncheon

Dr. Browning Presents Banquet Address

Guest Editorial . . .

WHAT DO YOU SAY, DOC?

I didn't know Ajax Carlson. But he said, "as between man and animals, man comes first. But when man uses or destroys the animal for man's own protection, aid or other interests, such use or destruction must be done without cruelty. I regard kindness to all animals as one of the finest and fairest fruits of human development, especially when the emotion of kindness is tempered and directed by a profound understanding of the complexity, beauty and unity of all life, man, animal and plant." A. J. Carlson was called "Ajax" because he was one of the Olympians of modern sciences, a physiologist to whom physicians are indebted as much for the scientifc turn of his mind as for the facts which he added to the profession—and he recognized the truth of valid sentience and he expressed it.

This seeking after the truth is not common. Even the scientist, afflicted by the phase of the sociological cycle through which we are falling, has sometimes been just a little blinded by the new light of the fantastically possible. But of more immediate concern to those in a scientific profession are the machinations of power hungry politicians. Acquisition of power requires time in office. Time in office results only from election victory. These people seek votes in blocs. Persuasion of voters is often based on sentimental romanticism if not downright lies. This is especially true in the field of restrictive legislation on animal experimentation. If the author of such legislation adopts a selfish and shortsighted point of view, he sees much to be gained. A more statesmanlike long range understanding of the effect of such legislation shows only a vast loss.

All those who work with animals in the interest of science know and feel what Ajax wrote. Yet into the Senate of the Congress of the United States has been introduced a bill (S. 533) to regulate any animal experimentation supported by federal funds. This bill is ostensibly aimed at promoting the humane treatment of experimental animals. Actually it is a strictly regulatory measure, producing its regulation as regulation is so regularly produced by our federal government today—by requiring such mountains of paper work that the end to be sought is not worth that much trouble. This same principle has recently been applied to the "expense account loop hole" in the tax laws with little gain and great loss economically.

An excerpt from the proposed legislation is reproduced below. Read it, and tired as I know you are, write the Senator of your choice what you think of the eventual effect of the bill.

Edmund Burke it was who said, "When bad men combine, the good must associate." He also said that "All that is necessary that evil shall triumph is that good men do nothing." Sit down and think a little, then write a little letter to somebody—maybe even a Senator. Where lies the basic value?

What do you **say,** doc?

Joseph B. Deisher, M.D.

88TH CONGRESS—1ST SESSION
S. 533

IN THE SENATE OF THE UNITED STATES

Section 1. ". . .

Sec. 4. Each person to whom a certificate of registration has been issued, every licensee under section 5 of this Act and each agency or instrumentality of the United States which uses live vertebrate animals for research, experiments, tests, or training shall comply with the following requirements:

(a) All premises where animals are kept shall provide a comfortable resting place, adequate space and facilities for normal exercise, and adequate sanitation, lighting, temperature control and ventilation;

(b) Animals shall receive adequate food and water and shall not be caused to suffer unnecessary or avoidable pain through neglect or mishandling;

(c) Animals used in any experiment which would result in pain shall be anesthetized so as to prevent the animals feeling the pain during and after the experiment except to the extent that the use of anesthetics would frustrate the object of the experiment, and in any event, animals which are suffering severe and prolonged pain shall be painlessly killed. Unless the statement on file with the Secretary pursuant to subsection (h) of this section specifies a longer period during which animals must be kept alive for essential purposes of the experiment or test, consistent with this Act and the rules and regulations hereunder, animals which are seriously injured as a result of the experiment shall be painlessly killed immediately upon the conclusion of the operation inflicting the injury;

(d) The post operative care of animals shall be such as to minimize discomfort during convalescence. All conditions must be maintained for the animals' comfort in accordance with the best practices in small animal hospitals.

(e) An accurate record shall be maintained of all experiments and tests performed. Procedures shall be employed to make possible the identification of animals subjected to specified experiments and tests, and a record shall be kept of the disposition of such animals;

(f) All cages or enclosures containing animals shall be identified by cards stating the nature of the experiment or test, or numbers which correspond to such a description in a record book;

(g) Painful experiments or tests on living animals shall be conducted only by persons licensed under section 5 of this Act or by students in an established training institution who are under the direct supervision of a licensee and all animals used by the students in practice surgery or other painful procedures shall be under complete anesthesia and shall be killed without being allowed to recover consciousness;

(h) No experiment or test on living animals shall be undertaken or performed unless a brief statement of what is to be done to the animals and of the object of the work is on file with the Secretary, except that such statement need not to be filed if the experiments involved (1) do not interfere with the animal's normal comfort and well-being or (2) cause no pain because the animal is under complete anesthesia before the experiment is begun and is killed without being allowed to recover consciousness. The Secretary may limit the numbers of animals used in experiments that cause pain.

(i) An annual report and such additional reports or information as the Secretary may require by regulation or individual request shall be submitted to the Secretary. The annual report shall specify the number of animals used, the procedures employed, and such other matters as the Secretary may prescribe, and shall include a copy of any published work prepared or sponsored by the reporting person or agency, involving the use of live animals; and

(j) Authorized representatives of the Secretary shall be given access to the animals and to the premises and books and records of the agency or person for the purpose of obtaining information relating to the administration of this Act, and such representatives shall be authorized to destroy or require the destruction of animals in accordance with rules, regulations, or instructions issued by the Secretary, in conformance of this Act . . .

Letters to the Editor . . .

April 30, 1963, Seldovia, Alaska

Physicians Placement Service
Council on Medical Service
535 N. Dearborn
Chicago 10, Illinois

Dear Sir:

I am writing to you for any suggestion or help you may be able to offer in finding a physician for this little town in "The Last Frontier". My husband and I came here from Virginia last July and have operated the little hospital which is owned by the town and looked after the population of about 500 permanent residents and several hundred more during the busy salmon fishing and canning season in the summer. We found it a wonderful place for us to live and have been extremely happy here until my husband was drowned in a boat mishap last month. I do not feel that I can handle the medical work and my family one. (We have five children aged 9 to 17). Therefore I plan to move back to Virginia in early August after the busiest season is over. This will leave Seldovia in urgent need of a doctor.

This is a rather unique town and medical situation. It is located on the Kenai Peninsula at the mouth of Cook Inlet. There is no access by highway. There is daily scheduled service by Cordova Airlines and a lot of charter plane traffic. Seldovia Bay is the safest harbor on Cook Inlet and the town has developed around the fishing industry. The harvesting and packing of King Crab is a year around business, while salmon fishing and canning are concentrated in the late spring and summer. Shrimp and Dungeness crab processing are done on a smaller scale.

The people here come from all over the "lower 48." A number of the fishermen are college graduates, some with professional training. They come for adventure, freedom, the chance of making lots of money fishing, escape from more conventional lives, and who knows what other reasons. We have found them varied, for the most part intelligent, and exceedingly interesting.

The geographical setting is the most beautiful I have ever seen. The town is built right on Seldovia Bay, in fact the fish processing plants are built on pilings out over the water, as are half of the other businesses. On three sides we are surrounded by low mountains and on the West we look out across the blue waters of Cook Inlet to the Snow covered Alaska Range, 80 miles away. The wilderness is at our back door. Little black bears occasionally come into town. There are no Kodiak bear or other big game in this immediate neighborhood but big game hunting is readily accessible not far away. Ducks abound. With moose, salmon, ducks, crab and wild berries in our freezer we have not found the cost of living in Alaska nearly as high as we had expected.

Medical problems include those seen in any general practice, with a fair number of cases of trauma on account of the active lives people lead. There are approximately a dozen deliveries a year. Anchorage is an hour away by air and problems too big to handle here can usually be flown out. Occasionally bad weather delays this.

The Seldovia Community Hospital has six beds and 4 bassinets. Facilities include an X-ray, a small laboratory, Heidbrink anesthesia machine, operating table, and a good supply of instruments. There are comfortable living quarters for a doctor and his family in the same building. The town furnishes heat, electricity, water and cooking gas. The practice is small. During the year we have been here we have seen from two to twelve patients a day. Much of the time there are no patients in the hospital. Realizing that there is not enough work yet to pay a doctor to stay here, the town guaranteed to the doctor before us and to us a certain net income. We in turn have looked after the hospital and office chores as completely as we could by ourselves. Both the town's financial resources and professional help are somewhat limited. At the present time there is only one available R.N. I believe that the town has a bright future and that the practice will increase. Meanwhile, having some free time and more than enough interesting things to spend it on, more than compensated us for the decreased income.

I have forgotten to mention that the climate here is the most ideal in Alaska. Summers are cool, 65 to 70 degrees. I find the cool air and warm sun very exhilerating. Winter temperatures rarely go as low as zero, but usually average 15 to 35 above. This is considerably warmer than Anchorage. Annual rainfall is about 60 inches or less, compared to 150 inches in the Alaska panhandle. July and August are usually rainy months. Some winters there is a good deal of snow but this winter we had very little—no white Christmas. Sometimes we have high winds for several days at a time, but the town is so sheltered by mountains that most of the time it is calm here, even when it is blowing hard over Cook Inlet. The long winter nights are really only for a brief period here. Our shortest day had above six hours of light and then they lengthen very rapidly. We already have 16½ hours of light, and in summer there is very little night.

I realize that this situation will not appeal to everyone. There is no television. Movies are two nights a week and somewhat aged. There is no country club living or keeping up with the Joneses. Main Street is a boardwalk along the bay. There are 5 or 10 miles of road (unpaved) in the vicinity and fewer than a dozen cars. The water and sewer systems leave something to be desired. However the water system is to be modernized this year and they are working on the sewer. There are three bars along the boardwalk and some people drink more than they should. But nobody molests children. The town is in many ways like many in the older states were fifty years ago. For us it and Alaska had much to offer.

I hope that you may have the opportunity to call this opening to the attention of someone to whom it may appeal. I will be more than glad to give any additional information to anyone who may be interested in coming here.

Thank you for any help you can give us.

Sincerely,
Betty Whitehead, M.D.

Editor,
Alaska Medicine,
610 2nd Avenue,
Anchorage, Alaska

Sir:

Hooray for Marjorie G. Fitzpatrick! She laid it on the line. The apathy of all American physicians—not only in Alaska—may result in "too little and too late."

Physicians have more than a professional responsibility to society; they have a responsibility as citizens—just ordinary people—to take a political interest and a political stand. Simply doing our professional job, including whatever charitable work we contribute for the benefit of our own souls, is **not enough;** if this is all we do we are inadequate as citizens, and as inadequates will be taken under the broad, guiding, smothering wing of socialism, just like all the other inadequates.

'Tis high time we got up off our poly-unsaturated fats and down off our self-erected pedestals—time we got right into the earthy mess of a political world we never made but have to live in and with. If we don't "get with it" and soon, we can live quiet, sophisticated, and well controlled lives in our ivory towers—especially the well controlled part.

Thank you Mrs. Fitzpatrick! Maybe a jab from you will help another doctor or two see the light, feel the heat, and take an interest.

Sincerely yours,
J. B. Deisher, M.D.

June 10, 1963, Box 359
Ketchikan, Alaska

Editor,
ALASKA MEDICINE

This is just being written to give you the dates of the '64 meeting here in Ketchikan, for announcement in the Alaska State Medical Association Jorunal. We would plan to have a business meeting the night of Tuesday, May 26th and have the meeting proper run from Wednesday, May 27th to Saturday noon, May 30th, 1964.

Cordially your,

RALPH W. CARR, M. D.
President
Alaska State Medical Association

June 17, 1963
1027 Fourth Ave.
Anchorage, Alaska

Elizabeth Tower, M.D.
718 K Street
Anchorage, Alaska

Dear Betsy:

Here follows a bit of medical news that might be of interest to you in forthcoming numbers of "Alaska Medicine."

The 12th Annual Eye, Ear, Nose and Throat Clinic in Kodiak was held June 10 through 14 of this year. This clinic was held at the invitation of Dr. A. Holmes Johnson, Dr. Bob Johnson and Dr. Bruce Keers. It was held on the second floor of the Post Office Building, part of the space being donated by the State of Alaska through the good offices of Judge E. V. Davis of Anchorage and Mrs. Bob Acheson Sr. of Kodiak. The thankless preclinic administrative chores were handled almost entirely by my wife Betsy, and our clinic nurse as on several years previously, was Mrs. Robert (Helen) Hall, R.N., wife of the owner of the Kodiak Airways.

Helping with the expenses of this clinic this time were the Alaska Department of Health and the the Alaska Native Health Service. Participating in the clinic as he has done since 1955, was Mr. John H. Spahn, the only Guild Optician of Alaska and the owner of the Physicians Optical Company. As President of the Eye, Ear, Nose and Throat Foundation of Alaska Incorporated he donated his talents in measuring for spectacles, those children who were wards of the various federal and state medical programs. Through the Foundation also those children who for various reasons could not qualify as beneficiaries of either federal or state medical program were given spectacles.

The more than forty children seen under the aegis of the Alaska Department of Health and the Alaska Native Health Service were gathered together on a proper day through the efforts of Mrs. Dora Kramer, R.N., Public Health Nurse for the Alaska Department of Health, who has been doing this kind of work with Mr. Spahn and me for several years.

Dr. Bruce Keers very kindly put Mr. Spahn and me up in his home during our entire stay. Supplying not only with a home in which to stay but also with a superb view of the islands and waterways and other superb scenery spread out before us. He also entertained us in the evening with hi fi tape recordings which were heally high in their fidelity.

After the days chores were over Dr. Bob and his wife Marian had us out to dinner in their beautiful rural retreat on the outskirts of Kodiak.

We saw well over one hundred patients and prescribed many sets of glasses. Many of the patients were "new" and many were "old." A few cases of mastoiditis were discovered. There were several children badly in need of having their tonsils and adenoids removed. Four cases were discovered that will need nasopharyngeal irradiation with radium. This of course would have to be done in Anchorage. All private as well as federal and state cases were referred to the three Kodiak Doctors for medical and surgical treatment when this was possible. Other patients will have to come to Anchorage for special treatment and surgery and still others will have to go to larger medical centers for modern care.

Our nurse, Mrs. Hall, was able to run the office in a style reminiscent of a war time command post. The Kodiak Telephone Company kindly strung us a separate line and with this Mrs. Hall was able to be in contact with the so-called island villages as well as with Kodiak itself. The clinic in my opinion was rousing success from everybody's point of view and represented the ultimate in cooperation between many individuals of an extraordinary diversity of interests.

With the greater demands on relatively fewer physicians the opportunity is available in everyone of the fifty states for all physicians whether in general practice or in specialty endeavors to spread their usefulness in their respective communities. The increased speed of air travel, the greater reliability of schedules, the virtually marvelous new systems of telephonic communication and the relative decrease in the cost of the transfer of individuals and air freight in modern aircraft, the average physician if he just wishes to do so, can increase his value to his community by undertaking itinerant clinics such as this. Of course in areas like Alaska itinerant practice is perhaps more stimulating and interesting than it would be let us say in the eastern portion of the United States. But even here the challenges exist and the opportunity of serving is there to be taken advantage of by any interested physician.

It is our hope that we will undertake the 13th Annual Eye, Ear, Nose and Throat Clinic in Kodiak in the spring of 1964.

Yours sincerely,
MILO H. FRITZ, M. D.

President's Page . . .

PRESIDENT'S ADDRESS

WILLIAM J. MILLS, JR., M. D.

Presented at the 18th Annual Convention of the State Medical Association, May 29, 1963

Members of the Alaska State Medical Association and guests, it is our privilege this morning to have with us in this opening session the Alaska Legislative Council. These members of our legislative body are interested in improving the standards of health care, in our state. They desire, as we do, to promulgate legislation pertaining to public health for the benefit of all Alaskans.

It is the aim of this society now and has been the desire of many members in the past several years, to rewrite the Medical Practice Act, and if possible to incorporate the act into a professional code. This code is planned for all individuals engaged in the healing arts, including physicians, osteopaths, dentists, pharmacists, nurses, physiotherapists, all drugless practitioners, optometrists, chiropractors or any others engaged in health practice in this state.

All of us, including all of those mentioned should be concerned that the professional code define properly, in adequate, simple and understandable terminology, the duty and privileges of each of the named, or unnamed as yet, title or practitioner, and that the requirements for licensing these individuals be equally well defined. That our members and other professional and lay groups in this state are interested in medical legislation is a matter of record dating back far into territorial status.

This society recognizes, as does the national organization of state medical boards of the United States, that in our case, the practice of medicine or other healing arts is necessary as a matter of policy in the interest of public health, safety, and welfare in order to provide laws and provisions covering the granting of that privilege, and its subsequent use and control. This in order that the public be properly protected against the unprofessional, improper, unauthorized and unqualified practice of medicine or other healing arts and from unprofessional conduct by persons licensed to practice those arts.

For our purpose we may utilize the definition of medicine as adopted by that same state federation of medical boards in 1956, namely "the practice of medicine by any person shall mean the diagnosis, the treatment or correction of, or the attempt to, or the holding of oneself out as being able to diagnose, treat, or correct any and all human conditions, ailments, diseases, injuries or infirmities, whether physical or mental, by any means, methods, devices or instrumentalities." This definition contains exclusions in the effect that the practice of medicine itself should not apply to a person licensed to practice a limited field of the healing arts which constitutes a part of the practice of medicine, and the provision of an act should never be construed to affect in any manner the practice of the religious tenets of any church or religious belief.

For many years this society has in the form of resolutions gone on record as to its interest in medical legislation.

In order to demonstrate for you our interests, I would like to review the history of our medical society meetings, year by year, since 1947.

In 1947, June 10, in the office of Dr. W. P. Blanton in Juneau, the Alaska Territorial Medical Association was incorporated. The Articles of Incorporation were written by Drs. Rude, Clements, Carter, Blanton, and Whitehead. Following incorporation the first Territorial Medical Association meeting was held in Fairbanks, in the chapel of the Mapleton Funeral Home. Dr. Paul Haggland was the first president pro tem and Dr. A. Holmes Johnson, president elect. Most of the business then was directed toward incorporation of the society and a scientific program was presented.

In 1948 a resolution was passed, introduced by Dr. Virginia Wright and Dr. James O'Malley, "opposing widespread commercialized prostitution in Alaska, and requesting legislation to formulate rules and regulations to prohibit the issuance of certificates to persons showing them to be free of venereal disease."

Dr. Earl Albrecht, Commissioner of Health, introduced a resolution for "legislation to provide the Department of Welfare with more financial support to see that the indigent sick in the state were well provided for."

Dr. Milo Fritz suggested a resolution "requesting the medical meetings to be held at Juneau at the time of the next legislative session, in order to work with the legislature on matters of health."

In 1949 Dr. Albrecht presented a resolution directed to the federal government, recommending the establishment and maintenance of an Arctic Health Research Institute for this state, to be placed, if possible, in the region of the University of Alaska.

Further resolutions were adopted regarding the development of a Bureau of Vital Statistics, a pure food and drug act, and a recommendation that the health laws of the state be rewritten, with further clarification of the basic science regulations. At that time, at that meeting, a discussion was had regarding diploma mills in certain parts of the State of Alaska. Further discussion was had recommending an increase in salary for the office of Commissioner of Health. It is interesting that in 1949, in opposition to Mr. Ewing, it was proposed by Dr. Whitehead in Juneau, that a resolution be adopted opposing the program submitted by the President of the United States for national compulsory health insurance, but reiterating the stand of the previous year as being in favor of prepaid hospital care. Further interest in health care was demonstrated that same year with a resolution requesting the dentists to provide post-operative care for the treatment of patients following tooth extraction.

In 1950 the basic science laws again were discussed and need reiterated for their revision. The society went on record as recommending to the state and the Department of Civil Defense, the stockpiling of goods, including medical goods.

At that time, too, for the first time on record, or at least on record in our minutes, Dr. A. Holmes Johnson of Kodiak, Alaska, permitted a break in an otherwise impermeable wall, recommending that the wives of members of the Alaska Territorial Medical Association be encouraged to form a ladies auxiliary. This was passed unanimously.*

In that same year, 1950, the society discussed drugless practitioners, advertising by paramedical individuals and radio and advertising claims for cure of cancer in the Southeastern area. It was recommended also that a public health committee be appointed by the Alaska Territorial Medical Association's president to consult and advise with the Department of Health of the Territory.

In 1951 a resolution was adopted encouraging the enlargement of the Pioneer Home facilities in Sitka, or elsewhere, to care for the aged. Dr. Whitehead of Juneau recommended investigation of the Florence Crittenden Homes and suggested that such a facility might be provided in the State of Alaska.

1952 a need was recognized for more hospitals in the Territory, and a resolution was passed to this effect. *Dr. Walkowski was elected Physician of the Year, and further widened the breach in the dike by himself requesting that the Women's Auxiliary be continued as a permanent function of the Alaska Territorial Medical Association and suggested that they take part in all its social activities. This resolution was unanimously approved and adopted. Neither Dr. Johnson nor Dr. Walkowski has held office in the State Association since.*

In 1953, in Sitka, interest in legislative matters was demonstrated when Dr. Blanton of Juneau suggested that the meeting in 1955 be held in Juneau to meet at the same time as the State Legislature. It was suggested further by Dr. Philip Moore, that the Alaska Territorial Medical Association be represented at the legislature during its session. A discussion was had of the "osteopathic, chiropractic, and other attendance law" passed by the Territorial Legislature as a rider. A further resolution was adopted recommending that the Alaska Mental Health Act, House Resolution 1217 be enacted, as the old act, the Organic Act, was archaic and inhumane and improper for Alaskans.

In 1954 further interest in medical legislation, particularly in regard to tuberculosis was demonstrated, and it was requested that more tuberculosis beds be provided for in the Territory. A discussion followed regarding "healers, reflexologists", and others using freely the prefix Dr. in advertising and on letterheads. It was noted that these individuals required only a Business License to practice "medicine" and again it was decided that it was nacessary to have representation on the floor of the Territorial House in Juneau to provide proper medical legislation for the Territory.

The membership noted that there was difficulty in getting bills introduced or passed in the state legislature, and therefore a legislative committee was appointed to formulate and present bills to the floor of the Territorial House. *(In that year, 1954, there was no mention of the Women's Auxiliary.)*

In 1955 there was considerable interest in regard to medical legislation by the Territorial Medical Association, including a recommendation for the establishment of health districts, the increase in health standards for trailer camps, interest in the presumptive death law, and further concern regarding mental health and its problems. Recommendations were made in favor of making prostitution itself, a crime in Alaska; regulating the practice of physiotherapists in Alaska; and listing the educational requirements for chiropractors. There was interest by the society in House Bill 64, the Dental Practice Act, in which physicians were denied the right to practice dentistry in emergencies.

A very interesting discussion was had regarding the United States Public Health Service, and the transfer or potential transfer of PHS facilities to the State of Alaska. This action was triggered by a letter from the Alaska Native Brotherhood recommending such legislation be enacted, followed by a letter from the United States Public Health Service, Director of Indian Affairs, with a final letter by Gov. Heintzleman, indicating that it would not be feasible for the State of Alaska at that time and probably in the very far future, unless federal financial support was provided, and soon forthcoming.

In 1956 the State Medical Association recommended legislation for the inspection of brakes, lights and safety equipment on automobiles, private and commercial, for the betterment of the general public health. A resolution was adopted to appoint a physician on the Board of Public Welfare.

In 1957 a review of the Medical Practice Act was once more recommended, since changes in medical education had occurred, graduate requirements had increased, and it was known that all established forms and customs require review. This review was suggested for the more efficient operation of licensing procedures, and improvement of the medical care in the Territory.

In 1958 Dr. Phillips stimulated a discussion of the need for changes in the Medical Practice Act, particularly in regard to expediting the granting of licenses and temporary permits.

Dr. Fate, the society president in 1958, joined the list of the anonymous by announcing that the Ladies Auxiliary had requested that they not be presented with floral corsages at the banquet, but instead have an equivalent sum in cash (which they planned to donate to the American Medical Education Foundation.) That same year, Dr. Phillips recommended a committee to study the act that controls the licensing of physicians with an eye to improving that act if necessary.

In 1959 the society met in Juneau at the Masonic Temple. A committee was appointed including Drs. Sparling, Moore, Whaley and Mills for study of the Maternal Child Health, Crippled Children's Service in the state. The committee was advised to confer with members of the legislature and the Alaska Department of Health in regard to these matters.

This conference was held, the members appeared before a legislative committee. Recommended legislation was not accepted, since at that time there was conflict between the members of the Alaska State Medical Association, particularly interested in that field, and the members of the Alaska Department of Health, over the need for such new legislation. This led, as you can imagine, to legitimate confusion in the ranks of the legislative body.

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* *Definition of auxiliary: 1) giving support; helping; aiding; assisting. 2) subsidiary. 3) used as a reserve. 4) a person or a thing that gives aid of any kind. 5) (pl.) foreign troops in the service of a nation (? medical society) at war. 6) Naval—a naval vessel designed for other than combat purposes, as a tug, etc. American College Dictionary, 1958.*

Mr. John Rader, then in the legislative body, spoke before the group and recommended that a professional committee be appointed to consult with the legislature regarding the operation of the recently combined Health and Welfare Departments. The society recommended in their resolutions the endorsement of Senate Joint Resolution No. 2 pertinent to the need of hospital and medical care in the state, and the continuance of aid to local community hospitals. This feeling was expressed to Senator Logan. It was further recommended that there be established a division of Public Health within the Department of Health and Welfare, and the head of this division be a Director of Public Health, his position to be established by Governor's appointment.

It was further recommended that the Governor appoint an advisory health council to advise the Director of Public Health on all matters affecting health of the people of Alaska. This advisory health council was to consist of nine members holding three to five year terms. They were to be chosen from various areas of the state, demonstrate a broad representation of health professions, agencies and the public at large, with no more than two members from any one profession or special interest group.

That same year a resolution was passed recognizing the need for official representation of the Alaska State Medical Association with the legislature, this position to be established for the purpose of officially representing the State Society in Juneau at the time the legislature met. Dr. William Whitehead was appointed to this position. A further resolution was passed recommending the Governor appoint a physician member to the Atomic Energy Advisory Board, a member trained in radiologic health and safety procedures.

In 1960, three interesting resolutions in a row were passed regarding the Veterans Administration. The first, that the Veterans Administration limit its care program to veterans with service connected disability only. The second, that in view of the Veterans Administration's expenditure of almost one billion dollars a year, with 80 to 85% of the Veterans Administration's care for non service incurred disability, that the Veterans Administration dispense with its building program immediately. The third, that since government hospital facilities are already available that could be used for the care of veterans with service incurred disabilities, that the Veterans Administration hospitals be turned over to the states in which they are located to be used as the states see fit. Thud! A resolution was further passed that the State Medical Association was opposed to Senate Bill No. 55 regarding the licensure and regulation of clinical labs and technologists. It was suggested if the Alaska Department of Health felt need for this legislation that the State Medical Association form a committee to discuss this matter with the Alaska Department of Health.

Again that year a committee was appointed to investigate the need for revision and modernization of the present Medical Practice Act, and if such need was found to exist, to work with the Board of Medical Examiners in revising the Act and requesting the legislature to make it law. Once more a resolution was adopted requesting the transfer of the Alaska Native Hospital System to the Alaska Department of Health and Welfare. Further recommendations were made regarding the development of foster homes and the care of children in those homes, since it was felt that children requiring long term hospitalization did better in foster homes than in hospitals.

In 1961 at Sitka, Dr. McBrayer in his opening address, recommended that legislation be enacted to increase the salaries of the professional personnel throughout the Department of Health and Welfare in order to obtain and keep men and women of high caliber in that department.

A letter from the Department of Health and Welfare had advised, according to the president, that the informality of the professional advisory committee as such, did not lend itself to the type of professional advice which might work to the best advantage of the Department of Health and Welfare as well as to the Medical Society.

The society that year urged the Alaska State Legislature to pass the Kerr-Mills Bill and oppose the King-Anderson legislation. We went on record as opposing further, the bill by Senators Cooper, Gruening and Bartlett recommending restriction on the use of laboratory animals for medical research, and in effect opposed the antivivisetion bill.

Further resolution was adopted by letter to the House of Delegates of the American Medical Association recommending a study of the relationship of medicine to optometry. A resolution was passed with information to the Attorney General that money from the land sales of mental health lands go to that organization, even over the expenditures allocated to the Department of Health by the legislature. This because of future needs in expansion of that organization. Once again revision of the present Medical Practice Act was indicated in the form of a resolution. A discussion was had of employing a professional representative at the state legislative meeting for each session. Further recommendations were made suggesting the separation of the Department of Health and Mental Health, and a resolution was passed requesting that community mental health clinics be formed throughout the state, utilizing state and local funds; we suggested support for any laws to further that purpose. Once again we asked that the Department of Mental Health and Public Health be empowered to offer salaries comparable to those in other states, for the same positions. It was further pointed out by the society, that in 2½ years of statehood there appeared to be lack of interest, or knowledge, in the Alaska mental health problems, and in the 2nd State Legislature a bill providing for a survery of all of Alaska's mental health problems by the American Psychiatric Association was not reported out of committee.

The society urged a comprehensive study of the present mental health needs of the state. The society further made recognition of the medical profession's awareness and concern over the failure of natives and part-natives to assume personal responsibility for their health and well being, even when financially able to do so. It was stated that the federal and state governments have no practical plan to arrange self sufficiency for the native. It was recommended, and passed in the form of a resolution that a council of physicians, ministers, businessmen, native leaders and educators meet and recommend to the state and federal government, in order to promote the developmnt of the Alaska native as a self sufficient and socially effective individual.

In 1962 Mr. Henry Camerot met with the Medical Association, having been the representative and advisor during the course of the legislature that year. A discussion was had of the adoption bill not passed, the professional incorporation bill, vetoed by the Governor, a marriage code, and a discussion of the bill on restriction of the use of x-ray by chiropractors, this bill returned to committee. The Kerr-Mills legislation and implementation bill was discussed and it was noted that this was not brought out of committee. Resolutions were adopted recommending that since adoption laws were inadequate that an effective legislation regarding adoption be developed. It was recommended that the membership participate in political action committee work to convey organized medicine's views regarding better care, quality and financing of health.

A resolution was adopted regarding legislation for the protection of the maternal and perinatal study, including medical audit study committees. The legislature was urged to pass enabling legislation for enactment of the Kerr-Mills bill. The society's view in opposition to King-Anderson bill was listed, stating that this legislation did not meet the situation needs, was expensive, and intefered with the physician-patient relationship, and tended to further encroachment by government in the medical care. There was noted a tendency for an increase in services of diagnostic and therapeutic nature to be offered by paramedical and non medical persons, without medical supervision. This was considered potentially harmful and in violation of the spirit, if not the letter, of the Medical Practice Act, and again the society was urged to investigate the Medical Practice Act.

At this time this year in Fairbanks resolution No. 15 was adopted (10 for, 7 against.) It stated that whereas the Women's Auxiliary had indicated it could make a greater contribution to the advancement or organized medicine through their own strong organization, and that in order to implement the request of the Women's Auxiliary, it was resolved to provide that the annual dues be collected by the treasurer of the Alaska State Medical Association, and be transferred then to the ladies for their own purpose. Dr. Ribar, under whose office this transaction occurred, no longer holds that office, and has been transferred as far south as possible. He is presently our delegate to the American Medical Association, in the South Forty-Eight pasture. Immediately after that, resolution No. 16 was passed, recommending that an advisory committee be appointed to the Women's Auxiliary to permit them to be aware of our actions and thus be in accord with the National Auxiliary and the Alaska State Medical Association. This was done.

It was further recommended that a legislative representative be present physically in the capital city during the legislative sessions. This was done with good effect the past year. Our representative in Juneau is now Mr. Frank Doogan of the law firm of Faulkner, Banfield, Boochever and Doogan. The society reaffirmed the appointment of an advisory council to the Alaska Department of Health.

Our concern for adequate health legislation has led to this joint meeting with the Legislative Council, to be held following this address. This meeting is our first session with the Alaskans who are responsible for developing and improving our laws. We greet them, as we do you, and welcome all of you to our 18th Annual Convention.

THE DISINHERITANCE OF KOBUK JOE

(Presented at the Alaska State Medical Association Banquet, May 31, 1963)

Drs. Johnson and Keers rehearsing

There are strange things done 'neath the midnight sun
By the men who moil for facts,
Who seek to know how the Eskimo
Metabolically reacts.
Where he stores his fat—why his feet are flat
Is all they wish to know.
Yet they found a lack that as we look back
Disinherits Kobuk Joe

Now Kobuk Joe was an Eskimo
Or at least was thought to be,
For he'd lived his life and he'd wed his wife
Out beside the Bering Sea.
Each Spring they'd show, as the melting snow
Revealed the winter's rubble,
That, in poverty, infertility
Was not this couple's trouble.

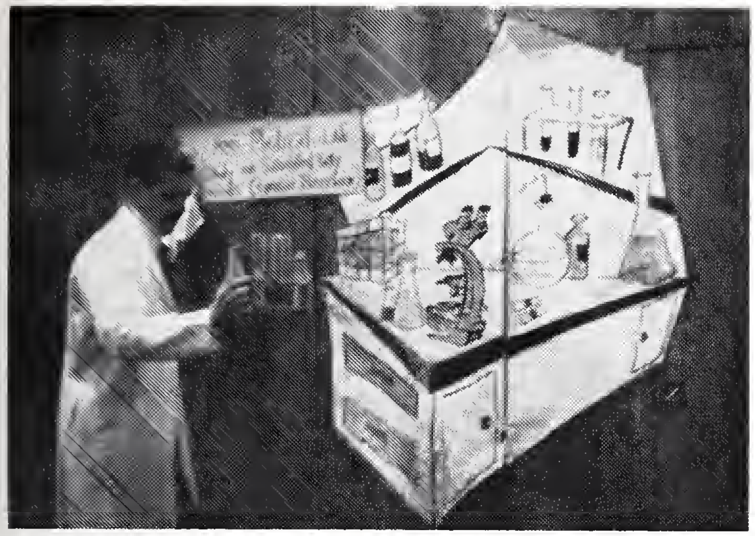
Each cloud in eight had a lining bright
For at least the kinds were free,
And he got the pills for their many ills
As a beneficiary.*
Where the four or five that had failed to thrive
Spent their winters—you can guess!
And another three only hear and see
Thanks to U.S.P.H.S.

When each month or two research teams passed through
Our family gave a cheer,
For Kobuk Joe always earned some dough
As their leading volunteer.
Yes, the lure of dough caused this Eskimo
To endure at their insistance
Minus ten degrees in his B.V.D.'s
To test his cold resistance.

Another group came seeking poop
On exactly what proportion
Of Eskimos had pigeon toes
And tibial distortion.
That his small fry might qualify
Joe made a simple brace
That, applied just so, made each leg bow
In the customary place.

There's a rumour that Eskimos eat fat,
So a group down South decided
That they should see histologically
Where this excess fat resided.
They implanted mesh underneath his flesh
And let it there remain.
In another year they did reappear
And cut it out again.

When they needed meat Joe could freeze his feet—
Then notify a team
Who would treat one toe with ice and snow
And another one with steam.
These medic mobs placed cotton swabs
In every sort of place!
No child or man in Kobuk's clan
Had a virgin oriface.



Now shift the screen to a stateside scene
In which the major actor,
A doc obscure, doing research pure,
Isolated "NATIVE FACTOR".
His conjecture ran that every man
Who inherits any fraction
Of native blood from his dam or stud
Should give a plus reaction.

Yes the factor rare always should be there,
So to prove this test was ample,
All the teams did rush to Alaska's brush
Every native blood to sample.
When he ran the test on all the rest,
The results were, to be sure,
Though quite in line, only ninety-nine
And forty-four one hundredths pure.

How he scratched his head! How he tossed in bed!
How he sought the booger factor!
For Kobuk Joe, full Eskimo,
Was not a plus reactor.
To solve his plight, he took a flight
To the village by the sea,
And began to stew over every clue
As to Joe's heredity.

He had been a wild communal child
As far as neighbors knowed.
Without a ma, a home, or pa—
Like Topsy—Joe "just growed."
In a village near lived an ancient seer,
So they deemed 'twould not be folly
To drive some dogs over frozen bogs
And consult one Muktuk Molly.

Narrative Poem—Elizabeth A. Tower, M.D.
Musical Background—Robert Holmes Johnson, M.D.
Narrator—J. Bruce Keers, M.D.
Settings—Mrs. Robert B. Wilkins

"On the very morn that Joe was born
I found his Ma adrift.
She chose to skip her factory ship
Lest the Russian crew be miffed.
She told her fears amidst her tears
And the reason she was blushin'.
Her sailor chap had been a Jap
And not a lordly Russian.

"With her labour through, she rejoined the crew
Of that Russian fishing ship,
But on me she piled the slant-eyed child
That might reveal her slip."

* * * * *

Yes the test was right—this removed the blight!
He returned with mind at ease,
For Kobuk Joe was not Eskimo
But a Russo-Japanese!

That Kobuk Joe would have to go
Was clear to his wife Ann.
The great largesse of the P.H.S.
Was a match for any man.
Should the family share his "bar sinister?"
All those pills would have to go!
—Thus science pure, did to be sure,
Disinherit Kobuk Joe.

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* Alaska Native Beneficiaries of the Public Health Service are classified as follows:

"Male: Alaska-born Indian, Aleut or Eskimo
Degree of blood at least one-fourth
Proved by birth certificate or Bureau of Indian records.

Female: Alaska-born Indian, Aleut or Eskimo
Single—Degree of blood at least one-fourth.
Married—Any female married to an eligible male is eligible and the dependent children are eligible.
Any female of at least one-fourth degree blood is not eligible if she is married to a white male unless she is divorced from a white male and not receiving subsistence, or widowed or separated and/or deserted for six months, or if her white husband has been committed to a penal institution for a felony."

MUKTUK MORSELS

A Column Devoted to
Medical News in Alaska

Compiled by

HELEN S. WHALEY, M.D.

GENERAL NEWS

The Fourteenth Alaskan Science Conference sponsored by the American Association for the Advancement of Science will be held at the Alaska Methodist University, Anchorage, from August 27 to August 30, 1963. Dr. David Duncan of the Greater Anchorage Health District will chairman the section on Medicine and Public Health. Thursday, August 29th will be devoted to a Tuberculosis Seminar conducted by the United States Public Health Service.

New officers in the American Academy of General Practice elected at the May A.S.M.A. Meeting include Dr. Bruce Keers of Kodiak, Alaska, President; Dr. Joseph Ribar, Fairbanks, Vice-President; Dr. Bob Johnson, Kodiak, Secretary; and Dr. Joseph Deisher, Seward, Delegate. New officers of the Alaska State Heart Association are Dr. Grace Field of Juneau, President; Dr. Paul Isaak of Soldotna, President-Elect.

The sixth annual Heart Clinic will be sponsored jointly in September by the Alaska Heart Association, Alaska Native Health Service, and the Alaska Department of Health in Anchorage and southeastern Alaska, probably at Juneau. The team again will be headed by Dr. Frank Gerbode, Surgeon at the Presbyterian Medical Center, San Francisco, and his fellow team members from both the Presbyterian Hospital and Stanford Medical School in Palo Alto. Details of this clinic are being arranged by Dr. Robert Wilkins. Announcements for referral of patients will be sent in the near future.

LOCAL NEWS

FAIRBANKS: Dr. Lawrence Dunlap has left Fairbanks with his family to start a three-year obstetrics-gynecology residency at the Medical College of Virginia. In addition to his extremely active obstetric and pediatric practice, Dr. Dunlap has been active on the St. Joseph's Hospital staff and the Fairbanks Medical Society, both of which he has served as chairman. Dr. William James, who was associated with the Tanana Valley Clinic, has left for the South 48. Dr. Jean Arnold, whose husband is stationed with the Military in Fairbanks, is doing general practice with the Tanana Clinic.

Fairbanks' first anesthesiologist, George C. Clark, arrived with his wife, Mary Clark, a social worker, this spring to set up independent practice. He is a graduate of Queens University, Kingston, Ontario, in 1949. He was in general practice in Calgary in 1949 and 1955. His post-graduate training was at the University of Toronto Hospital for Sick Children. He was a clinical instructor there until he came to Fairbanks. He is particularly interested in pediatric anesthesiology. Dr. Joseph Ribar of Fairbanks was awarded the Community Service Award at the 1963 State Medical Convention because of his outstanding service to the Fairbanks community, which he has served as mayor as well as in a number of other capacities.

SAND POINT: Dr. Carl Sandberg, who attended the State Medical Meeting, reports that his new medical clinic is almost completed. He has built this with the help of his father and his wife in a completely isolated area, which formerly had no medical facility.

BETHEL: Dr. Harriet Jackson Schirmer attended the State Medical Meeting and then flew with her husband and young son in a Cessna 172 for a trip to the East Coast.

ANCHORAGE: On Sunday, June 16, the new 45-bed Presbyterian Community Hospital was officially dedicated and the first patients were admitted the following Tuesday.

Dr. Gilbert Blankinship, formerly an internist with the United States Public Health Service in Anchorage, has returned from Louisiana to start private practice. Dr. Blankinship graduated from Medical College of Virginia in 1956, interned at Norfolk General Hospital, Norfolk, Virginia, and had his first year of residency at that institution. He also had residency in Charity Hospital of Louisiana in New Orleans, and has spent two years in Anchorage. Dr. Robert J. Alzner, anesthesiologist at the Alaska Native Service Hospital and a 1958 graduate of the University of Oregon, will enter private practice in Anchorage this summer. He is particularly interested in pediatric anesthesiology. He interned at Providence Hospital, Portland, Oregon, with residencies at the University of Oregon Hospitals and Clinics. He has been associated with the United States Public Health Service here. Dr. Glen Ogden, a 1937 graduate of Loma Linda, will be the radiologist associated with the new Presbyterian Community Hospital. He has been chief of radiology at the USPHS Hospital, Seattle and Boston; is a diplomate of the American Board of Radiology; and is formerly of Everett, Washington. Dr. John Pennington, formerly anesthesiologist at the 5040th Air Force Hospital, will be new Chief of Anesthesiology at the Presbyterian Community Hospital.

Dr. Rosalie Shohl recently completed her Anesthesiology Boards in Arizona. Dr. William Burr of The Doctors Clinic will transfer his practice to northern California this coming summer. Dr. Winton Wilcox, also of The Doctors Clinic, has started a psychiatric residency at the University of North Carolina in Chapel Hill. A mountain-climbing first was accomplished by Drs. George Wichman and Rodman Wilson, along with Paul Crews and Paul Crews Jr., of the Alaska Mounteering Club, this May, in reaching the summit of 12,600 foot Mount Gerdine, tallest unclimbed mountain the Alaska Range. They were flown in by Lowell Thomas, Jr., who was also a member of the climbing team. Dr. Wilson left shortly thereafter for a month in Switzerland, where his family will spend three months.

Medical Meetings were attended by Dr. Don Val Langston, Pediatrician, who went to the Chicago AMPAC meeting; Drs. Robert Whaley and Winthrop Fish, who attended the American College of Physicians meeting in Denver and the F.A.A. Meeting in Portland; and Dr. Peter Koeninger who attended the National Conference for Legislative Action of the American Medical Association in Chicago in April. Drs. Lawrence Dunlap and Bob Johnson also attended the latter meeting. Electra Koeniger attended the Secretary's Workshop of the American Association of Nurse-Anesthetists, also in Chicago.

Dr. Nancy Syndam has joined the many fliers in the area. Dr. Glen Crawford is the new President of the Anchorage Symphony for 1963-64.

Dr. Royce Morgan was joined in late June by Dr. Warren R. Jones, a University of Nebraska graduate with special training in general practice, and former service at the military hospital in Fairbanks. Dr. and Mrs. Jones have four children.

Dr. Howard Romig has been named among the new Fellows of the American College of Obstetricians and Gynecologists.

Dr. Robert D. Whaley was honored at the State Convention with designation as Physician of the Year for his work in organizing the Sabin Oral Vaccination Programs not only in Anchorage but in other Alaskan communities.

HAINES: Dr. Philip Jones has left Haines to take a Public Health residency. His place will be taken by Dr. Stanley Jones.

CORDOVA: The Drs. Chapman have recently finished their new office with much of the construction work being done by Dr. John Chapman.

UNITED STATES PUBLIC HEALTH SERVICE

ARCTIC HEALTH RESEARCH: An isolated outbreak of rubeola on St. Paul Island has drawn the attention of Drs. Jacob Brody and Robert McAllister of the Arctic Research Center, who have the assistance of Major Bob Cutting of the Army Epidemiology Corps. A rubeola vaccine program will be instituted immediately in this isolated area which has had no rubeola since probably 1943. The epidemic is presumed to have started when a child returned to the island in mid-June with the disease.

NATIVE HEALTH SERVICE: Dr. Kasuga has been transferred to Washington, where he will be Assistant Chief of the Division of Indian Health and Chief of the Office of Program Services. Dr. Holman Wherritt will be the new area director. He was formerly the MOC at the Anchorage installation.

New MOC at Mt. Edgecumbe will be Dr. George Wagnon, well-known to many Alaskans as he was formerly MOC at Kanakanak and Bethel.

Effective June 24, 1963 all commissioned Public Health Service officers will wear uniforms while on active medical duty. This is the first time in the Division of Indian Health Services that uniforms have been required but it has been a longstanding policy in the Division of Public Health hospitals.

Acting Medical Officer in Charge for the coming year at the Anchorage installation is Dr. Gloria Park.

Dr. Stewart Rabeau, long-time MOC at Kotzebue and the Area Deputy Chief for Alaska, has been appointed Deputy Chief of the Division of Indian Health, Washington, D.C.

FORT RICHARDSON: Dr. Tom Kelly, who was a pediatrician at the Fort Rich Dispensary for the last three to four years, has started a residency in pediatric neurology at the Boston Children's Hospital.

IN MEMORIAM

CASSIUS C. CARTER, M. D.

Dr. C. C. Carter, long-time Juneau surgeon and physician, died at St. Ann's Hospital March 5 following a prolonged illness due to a brain cancer. Funeral services were held March 7 in the Northern Light Presbyterian Church in Juneau with burial in Newberg, Oregon, the family home.

Dr. Carter, was born in Lynn, Indiana, on July 14, 1899, graduated from University of Oregon and its Medical School. He came to Alaska in 1932 as medical officer in charge of the Alaska Native Hospital at Tanana. He became chief of the Alaska Native Clinic at the old Government Hospital in Juneau in 1934.

In 1936 he founded the Juneau Clinic with three other physicians, Dr. William Whitehead, and the late Drs. W. W. Council and W. P. Blanton. At the death of Dr. Council in 1943, Dr. Carter was appointed interim Territorial Commissioner of Health. He was Juneau city health officer from 1943 to date, physician for the federal jail from 1944 to 1953, and consultant physician for the Selective Service Board during World War II.

Dr. Carter was thought of by his friends as a true "pioneer" physician, for he never hesitated to make emergency sick calls to isolated communities by boat or by plane regardless of weather or risk. An ardent sportsman, Dr. Carter was a member of the Territorial Sportsmen Association and a charter member of the Juneau Yacht Club. He was an active member, trustee and elder of the Northern Light Presbyterian Church, and a member of the Elks and Rotary.

Dr. Carter was a member of the American Medical Assn., the Alaska State Medical Assn., of which he was a past president, and the Juneau Medical Society, of which he was a past president. He was a past president of the Board of Medical Examiners, to which he was appointed by the governor. He was also a member of the Pan Pacific Surgical Assn.

Surviving Dr. Carter are his wife, Esther T. Carter; a son, Robert T. Carter of Spokane, Wash.; a daughter, Carla Wallace of Seattle; his mother and father, Mr. and Mrs. Frederic E. Carter of Newberg, Ore.; two brothers, Pierre of Laguna Beach, Calif. and Thomas M. of Manila, P.I.; and two grandsons and a granddaughter.

—William H. Whitehead, M.D.

PHILIP CARY WHITEHEAD, M. D.

What started as a fulfillment of many years desire turned out in a tragic ending on March 27th, 1963 in Seldovia Bay for Dr. Philip Cary Whitehead. Dr. Whitehead was born in Chatham, Virginia on Oct. 21, 1914. He went to elementary school and entered Hargrave Military Academy for 4 years at Chatham, Virginia. He spent two years at Virginia Poly Tech Institute after which he entered the West Point Military Academy and graduated with a commission 4 years later in 1936. He then taught one year at Hargrave Military Academy after which he resigned his commission in 1937, and started Medical School at the University of Virginia. He graduated from the Medical School in 1941 and spent 1 year internship at Montreal General Hospital. He then spent 7 months at Bellevue Hospital after which he went into the Navy Medical Corps in early 1943. He was assigned to the Marine Paratroopers in the South Pacific and served in the South Pacific Theater during World War II from 1943 to 1945. He was then stationed at Norfolk, Virginia and was discharged from the Navy in June of 1946.

Both Cary and Betty Whitehead were in the same class at the University of Virginia Medical School and both graduated in 1941. They were married on Christmas Day of 1941 and have five children; John Henry, aged 17; Hugh Cary, age 13; Gordon, age 12; Katie, age 10; and Cam, age 9. They moved to Chatham, Virginia in 1947 and were in practice there for 15 years. In 1961 they came to Alaska with the intent to homestead but couldn't find a suitable location and on the advice of Dr. John Fenger in Homer, Alaska they came to Seldovia after going back home to Virginia, arranging their affairs there and driving up over the highway with their personal effects and family. The family arrived in Seldovia on July 1, 1962 and has thoroughly enjoyed their stay in this community.

Dr. Philip Cary Whitehead is survived by his wife Betty and their 5 children, and by two brothers and 4 sisters: Mr. Richard Whitehead of Kirkland, Arizona; Mrs. Anna Henry of Blacksburg, Virginia; Mrs. Laura Young of New York City; Elizabeth Whitehead of Chatham, Virginia; Mrs. Katie Elliot of Belvidere, New Jersey; and Camden Whitehead, Chatham, Virginia.

—Paul G. Isaak, M.D.

ALASKA MEDICINE

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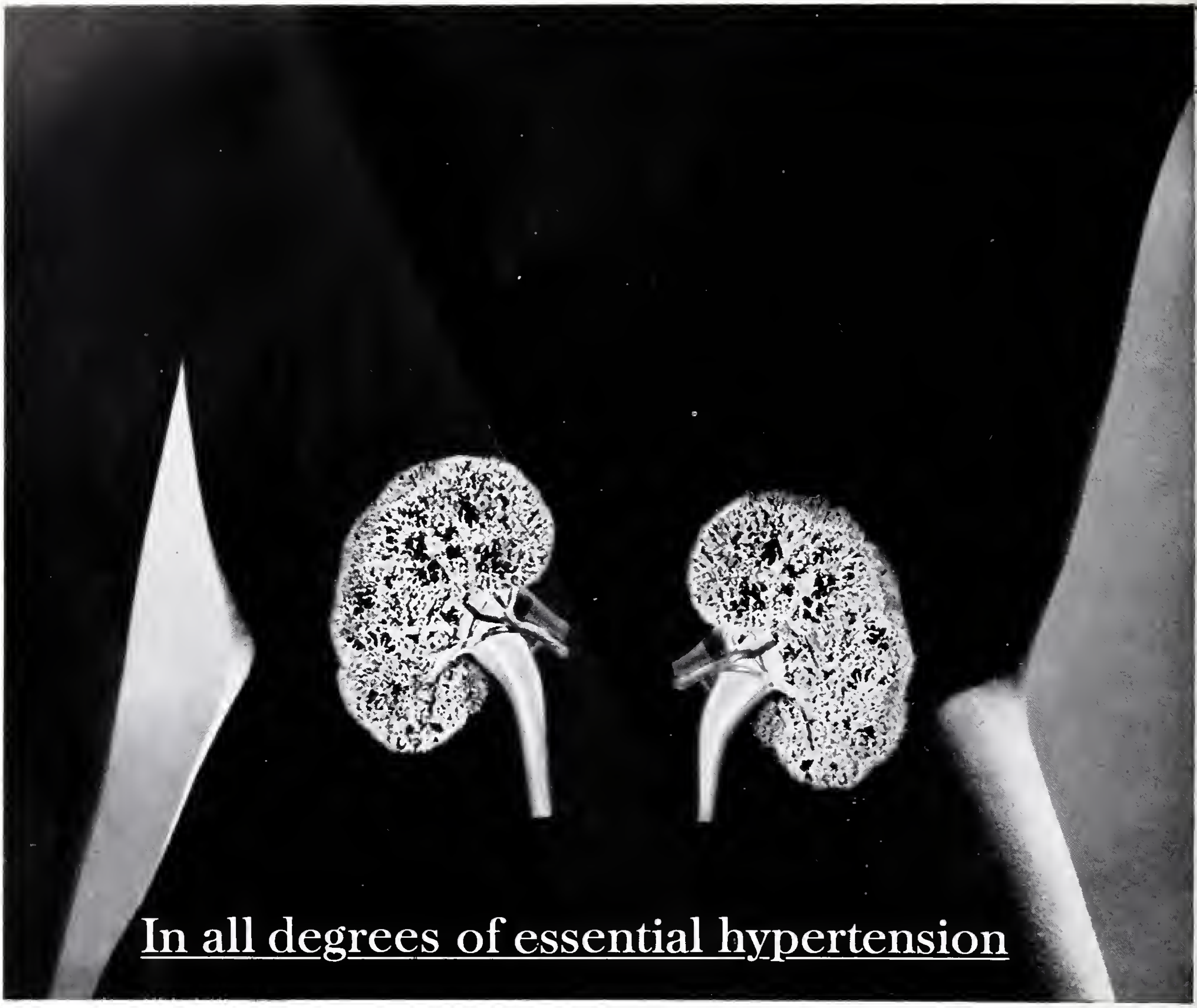

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Preliminary Studies on
SEAL OIL LIPID PNEUMONIA IN ESKIMO CHILDREN

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United States Public Health Service Hospital, Kotzebue, Alaska

(Presented at the Alaska State Medical Association Convention, Anchorage, Alaska, May 31, 1963.)

A perplexing and serious medical problem along the Arctic coast has been the occurance of pneumonias in infants and children which result in permanent pulmonary scarring. These pneumonias are clinically consistent with acute bacterial pneumonitis; however, they are atypical in respect to the high incidence of pulmonary scarring and bronchiectasis following these acute episodes. This problem has been studied from many angles including: multiple bacteriological studies for both tuberculosis organisms and pyogenic bacteria, protein electrophoresis for agammaglobulinemia, sweat test for fibrocystic disease and eosinophil studies for Loeffler's syndrome. These have been uniformly unsuccessful in determining a common etiology.

The suggestion was made that these pneumonias resemble, in many respects, the pneumonias produced by the inhalation of lipids, commonly seen in the South 48 when children aspirate cod liver oil, mineral oil, etc. In the coastal areas of Alaska the seal and other sea mammals remain a mainstay of the native diet. The animal is utilized in many different ways and one of the more valuable byproducts is the rendered seal oil. With this in mind, several Eskimo mothers were questioned as to the use of seal and other oils in infants and children. The inquiries produced the information that seal oil is not only used as a food at an early age, but it is also commonly used to loosen coughs in small children and infants. It is frequently administered by allowing a teaspoon full of oil to run down the supine infant's throat. The mothers state that this tends to loosen the cough.

The hypothesis was proposed that the high incidence of pneumonia with pulmonary scarring is a result of seal oil lipid pneumonia. Clinical and epidemiological studies substantiating this hypothesis are as follows.

In order to determine to what extent seal oil is used both for food and for medicine in the Eskimo culture, we asked the following questions of the native health workers in the outlying villages, located in our Kotzebue Service Area.

1. At what approximate age is seal oil given to children for food?
2. Is seal oil used to loosen coughs in small children? If so, how is it given?
3. Is seal oil easy to obtain in your village?
4. At what time of the year is seal oil most plentiful?

The answers to these questions varied with the geography of the area and with the local customs; however, general trends and practices were definitely evident and supported the hypothesis that seal and other oils are used freely and abundantly, both for food and for medicine in all ages.

In answer to the question as to what age is seal oil given for food, it was found that the age varied from birth to 5 years of age. The most common age was when the child begins to take solid foods—about 9 to 12 months of age. One villager stated, "We give a few drops of seal oil at child's birth. I myself have eleven children born to us. We all giving seal oil from since day old." Eighteen of the 21 villages reporting, gave seal oil as food to their children at the age of one year or less. The other villages began seal oil at a little older age.

Question two, concerning the use of seal oil to loosen coughs was answered in the affirmative in 17 out of 21 villages. The seal oil was given by teaspoon to loosen coughs even in the smallest infants. The oil is generally boiled, cooled and then allowed to run slowly into the infant's mouth. Seal oil is also rubbed on the chest, put in draining ears, and when boiled is considered to be a fine physic. Seal oil is used for lacerations and as an ointment for impetigo. Letters from the coastal islands say that fresh walrus blubber, oogruk and walrus oil, as well as seal, are used for food and medicines. The inland river villages report that fish intestines are boiled and the oil skimmed off the top and this is used much in the same way that seal oil is used on the coast.

Seal oil was noted to be abundant all year except in some of the inland river villages. Seals are most plentiful in spring and fall, but the oil is a year round commodity in the most meager of homes.

Summarizing information from the villages reveal that seal oil is: abundant and easily obtainable year round in most arctic coastal areas; a source of food available to children of all ages, but is usually started near one year of age; used commonly in infants and children to loosen coughs and to relieve other ailments.

In order to understand better the nature of pneumonia along the arctic coast of Alaska all of the Kotzebue hospital admissions in which the diagnosis of pneumonia was recorded and in which current x-ray confirmation was possible were compiled. In all of the cases studied, the possibility of active tuberculosis was thought to be remote and all of the known tuberculins were negative.

Following re-evaluation of the chest films, histories and physical examinations, 76 cases were compiled and studied. These cases were treated at Kotzebue Hospital between the dates of September, 1959 and February, 1963 and covered an age span of two to 96 months. The compiled data revealed several interesting facts concerning the nature of pneumonia in our area.

Forty-eight percent of the pneumonic processes involved the upper lobes of the lungs and 42% involved the right upper lobe. The remaining areas of the lungs were involved in the following percentages: RML 15%, RLL 15%, LUL 6% Left lingual 6%, LLL 8%. Diffuse involvement without definite lobar distribution was seen in 8% of the cases. This distribution of RUL is consistent with the distribution of lipid pneumonias, especially as the disease is seen in infants.

Cases admitted between February, 1962 and February, 1963 were evaluated as to incidence per month. These totaled 57 cases and exhibited a definite fall and winter increased incidence in pneumonia among the cases studied. This was thought to be consistent with the incidence of pneumonia in most areas of the country and did not seem to be peculiar to the Arctic Coast.

Comparing age with the incidence of pneumonia revealed that 75% of the cases were under the age of 22 months of age with the peak incidence at age 12 months. This suggests a correlation between the onset of oil consumption and incidence.

In order to substantiate the correlation between seal oil and pneumonia in children and infants, a hospital clinical trial was carried out utilizing the following procedure. All children with pneumonia admitted during a three-month period were kept NPO except for water for a period of 14 hours. (This included medications in that tetracycline suspension was found to stain with Sudan III. However, the morphology of the tetracycline staining particle was eliptical and of uniform size. This differed markedly from the fat particles which were globular and varied in size.) Following the fast, sputum was collected by suction. A cough reflex was elicited by a tongue blade and the coughed material was collected. The suction equipment was cleaned with fat dissolving solution and was autoclaved prior to use. The sputum was then stained with Sudan III and immediately examined for fat globules microscopically. The sputum was also stained with Wright's stain to study intracellular particles.

Thirty-two cases ranging in age from one month to 5 years were examined in this manner. Significant numbers of fat globules intra and extracellularly were found in nine cases or 28 percent. The fat staining particles in the sputum had the same staining qualities as did seal oil when tested separately.

Summary. The problem of bronchiectasis following repeated episodes of pneumonia was studied from the suggestion that this major medical problem is due to seal oil lipid pneumonia. It was found that: seal and other oils are abundantly and universally used as food in small children and are commonly used medicinally to loosen coughs in the smallest infants; 48% of the pneumonias involved the upper lobes of the lungs; the major share of the pneumonic processes are in children under the age of two years; 28% of the pneumonias studied in a 3-month hospital-clinic trial exhibited Sudan III fat staining granules in fasting sputum.

It is our opinion that, the hypothesis—the incidence of lipid pneumonia is high among Eskimo children is supported and that further clinical and epidemiological studies are warranted to further substantiate this preliminary study.

HAZARDS TO THE CONTINUUM OF GENETIC POTENTIAL

GELBERT W. MELLIN, M.D. and VIRGINIA APGAR, M.D., M.P.H.***

We, as unique individuals, have been derived from a genetic potential. This continuum of genetic potential has existed in three distinct phases: (1) preconception, (2) fetal life, and (3) postnatal.[1] (Figure 1) Warkany[2] has illustrated this concept in a different fashion. (Figure 2) This genetic potential which ultimately results in an individual has existed within a continually changing physical-chemical environment, and has been influenced by the parameters of quantity, quality and time. (Figure 3) The ideal goal of medical science is to insure a healthy individual physically, intellectually and emotionally. Let us consider some of the known hazards to this continuum of genetic potential, and how their effects may be prevented or rectified.

A. PRECONCEPTIONAL PERIOD

1. Inheritance from Forefathers

This interaction of genetic potential and environment has resulted in change of the potential through mutation and natural selection. These are the bases for evolution.

August Weisman, a German biologist, 1834-1914, stated, "The theory of the continuum of germ plasm is founded upon the idea that heredity is brought out by the transference of one generation to another, of a substance with a definite chemical, and above all, molecular constitution. I have called this substance "germ plasm", and have assumed that it possesses a highly complex structure, conferring upon it the power of developing into a complex organism."[3, 4] Today we might say that the continuum of germ plasm is founded upon the idea that heredity is brought about by various permutations of nucleotides, having the molecular constitution of desoxyribonucleic acid (DNA). The grouping of a thousand or so units of DNA may be called a gene. Genes are the substance of chromosomes which possess a highly complex structure, conferring upon them the power of developing into a complex organism.

Change and selection of this genetic potential is an exceedingly complex process and it is difficult to assess the relative effect of various casual factors. However, as our environment changes in various ways, pharmacologically, radiologically, and nutritionally, etc., mutations and natural selection of genetic potential continue.

2. Inheritance from our Parents

Father and mother each contribute 23 of our 46 chromosomes, even though the egg is huge in size compared with spermatozoa. Sex linked traits are passed by the father through his X chromosome to his daughters, who in turn pass it on to half their sons. Only two genes are thought to be part of the Y chromosome. One which is quite common in India and Ceylon is for a hairy pinna of the ear. It is limited to the male sex and transmitted in a dominate fashion.[5] The Y chromosome must also be present for an individual to have a male phenotype. In this situation the number of X chromosomes does not influence the phenotype. Even an XXXXY chromosome pattern produces a male phenotype.

Sudden obvious changes in genetic potential within a generation have been erroneously called spontaneous mutations, because the cause was unknown. A most famous illustration of this was the tendency for hemophilia among the royalty in Europe, which was introduced through Queen Victoria but did not exist previous to her time.[6] All mutations are not sudden and obvious. Many are much more subtle.

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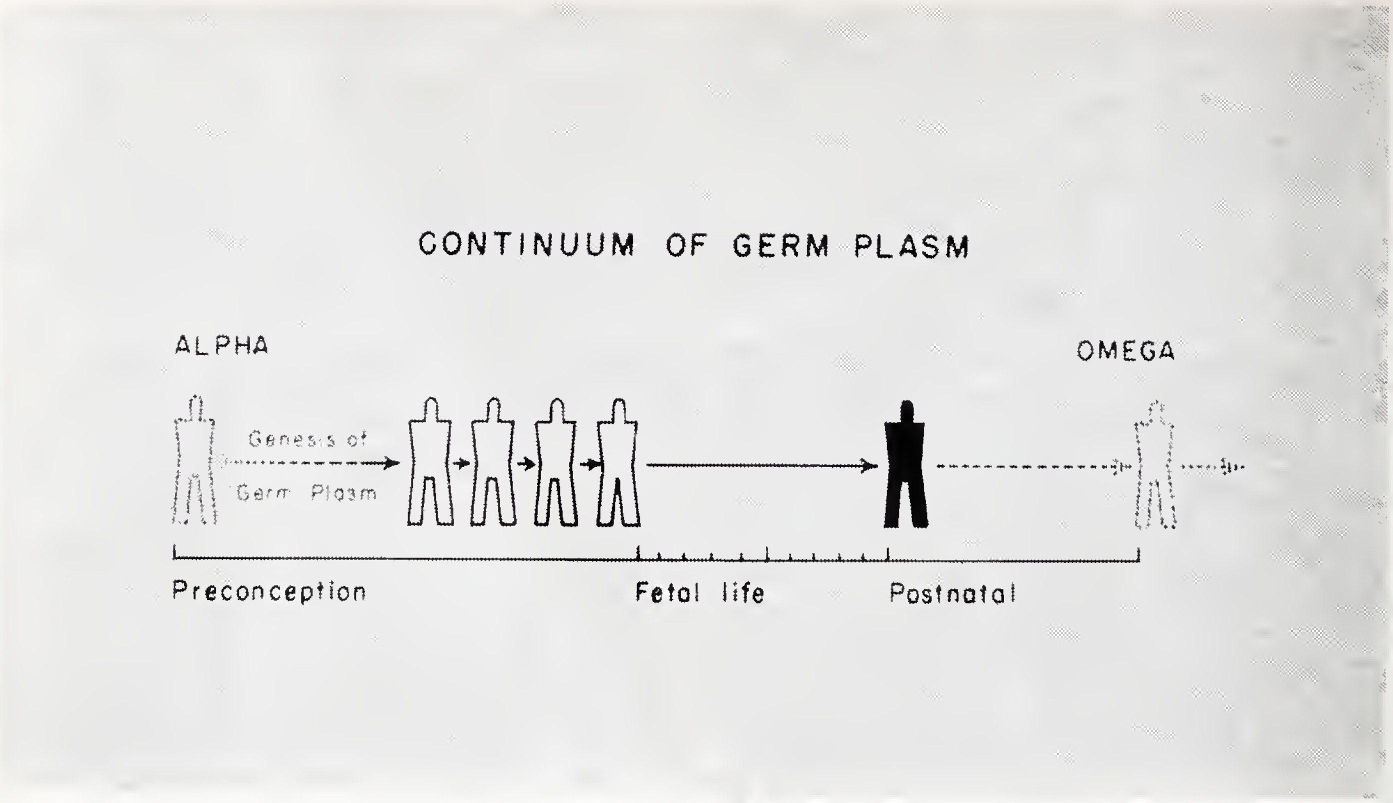

Figure 1.

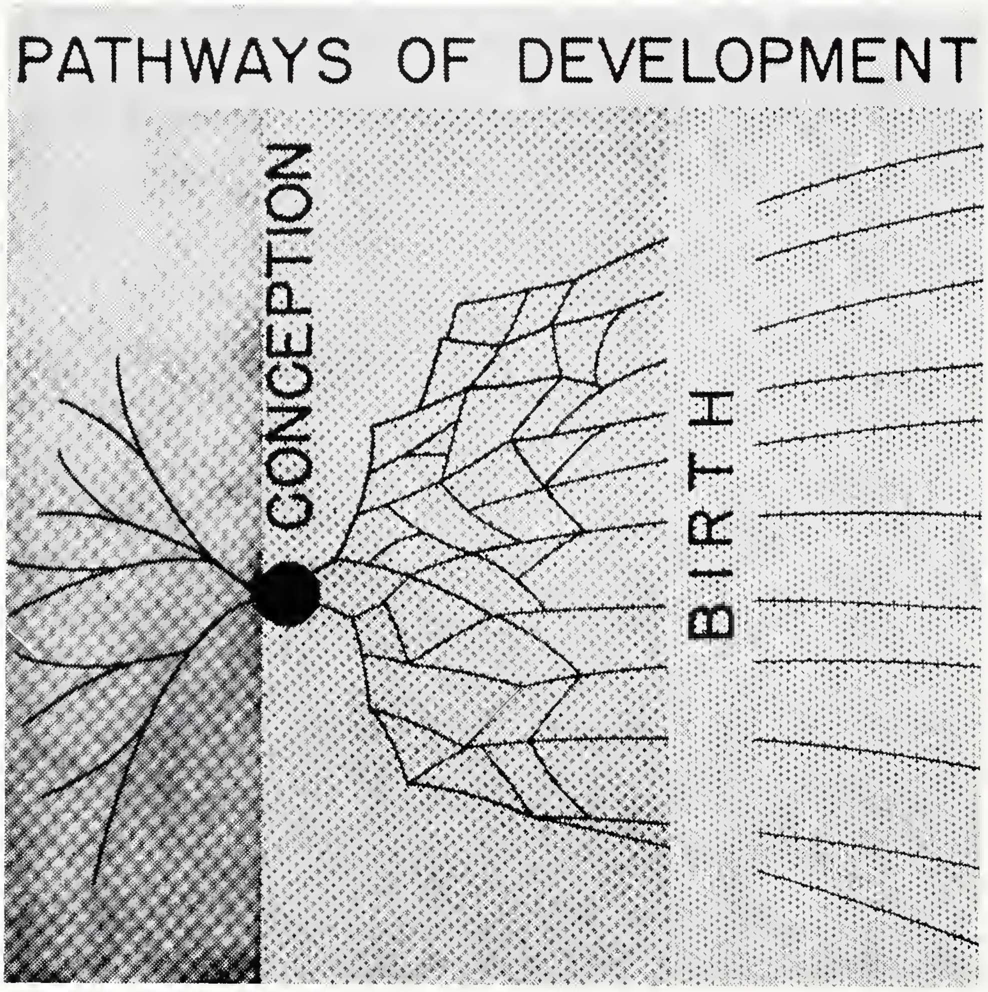

Figure 2.

We thank Dr. J. Warkany for permission to use this Figure.

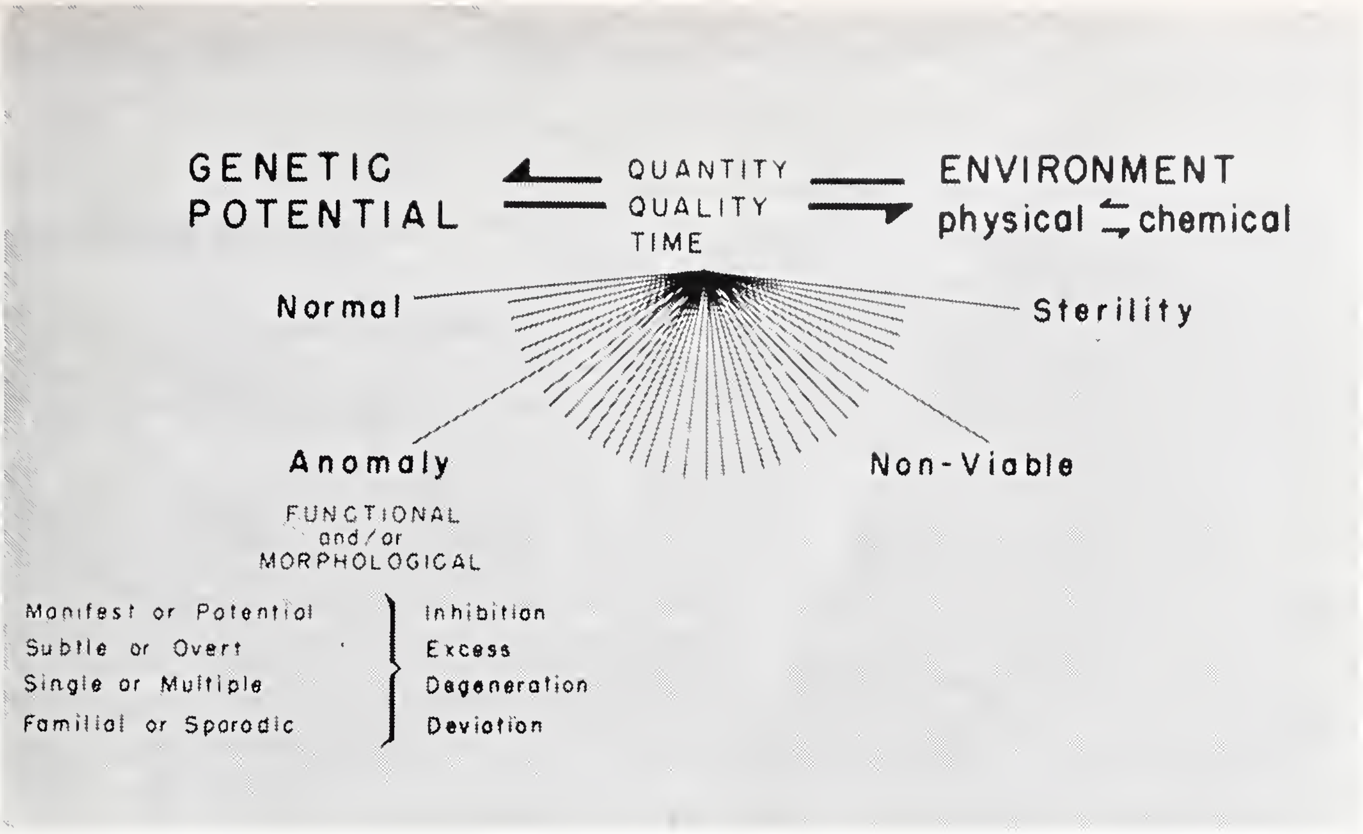

Figure 3.

Ionizing radiation is a known cause of mutation. Table I presents some of the sources of known radiation. Since mutations occur in a linear proportion to exposure there is no "safe" level. From monolayer human tissue culture studies it would appear that there is no minimal dose of radiation below which chromosomes will not show breakage during cell division. Fortunately, most chromosomal breakages heal normally. Abnormal reconstitutions may result in cell death.

TABLE I

GONAD DOSE LEVELS IN THE UNITED KINGDOM

Source	Annual Dose Rate (millirads per year)
Natural Background	85 to 106
Medical radiology (1957)	19
Misc. source (TV, shoe x-rays, etc.)	1
Occupational exposure (1959)	0.5
Fall-out: average value over five-year period 1955-1959	2.4

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A controversial study suggests a relation between Mongolism and radiation before conception. Uchida and Curtis compared the abdominal radiation history of mothers of Mongol children with matched controls in the same neighborhood and found approximately four times the radiation dose in the mothers before the Mongoloid child was conceived.[7] There may be a memory bias in these data. Neel's data derived from the Japanese atomic bomb experience revealed more Mongols in a control series than in those exposed to radiation.[8] Studies are now underway to investigate the fate of the progeny of the radium watch dial painters who did not succumb from osteosarcoma.

Viruses can also have a direct effect on the continuum of genetic potential. The mumps virus causing orchitis is known to be associated with sterility. There is evidence that certain viruses can affect the division of chromosomes. Stoller and Collman have suggested this as a possibility in the trisomic type of Mongolism.[9]

Certain chemical environments are detrimental to the egg and sperm. There is no indication, however, that the use of spermicide is associated with the birth of abnormal children. On the other hand, the sexual behavior of roosters hatched from eggs dipped in progesterone is distinctly altered. Even though they appear to be phenotypically male, few if any sperm are obtained from their testes.

Animal experiments have shown that nutritional deficiencies and accesses may be associated with infertility and increased abnormalities among the offsprng. There are no convincing studies concerning human nutritional deficiencies or accesses in relation to damage of the developing ova or sperm.

What can be done to protect the potential parent? The entire life cycle of the sperm is approximately two months. All the anlage of ova, however, would appear to be present at birth. Therefore, it may be assumed that ova could be damaged throughout the lifetime of the female whereas if a man were exposed to a radiation accident, complete regeneration of spermatozoa would occur after two months.

B. FETAL LIFE

Fetal life begins with conception and continues until complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy.[1] Death during this period is defined as a fetal death.[10]

1. Conception

The new frontier of periconceptional morbidity and mortality still remains a challenge. Noyes has used the term "capacitation" to describe the changes undergone by the sperm after entering the vagina and before penetrating the zona pellicuda of the egg.[11] The nature of the enzymatic dissolution of the zona pellucida which allows for the entrance of one and only one sperm needs further study. The antigenic nature of gametes and their immunologic incompatibility may be responsible for terminating or altering this genetic potential by resulting in unsuccessful or abnormal fertilization.

At this stage the genetic potential is reflected not only in germ plasm but also in somatoplasm. We are just beginning to understand the first mitoses of a new zygote, both morphologically and biochemically. The DNA of both gametes doubles just before the first cell division. The disappearance of the nuclear membrane during mitosis, usually at metaphase, exposes the chromosomes directly to cytoplasmic influences. The nature and extent of these influences has yet to be defined. In addition to several forms of ribonucleic acids (RNA) there would appear to be a cytoplasmic DNA with a different coding from the nuclear type DNA. Thus the "environment of mitosis" may have direct influence on perfect reproduction of chromosome and may be responsible for nondisjunction, anaphase lag, and even loss of a chromosome.

2. The Preimplantation Week

The fertilized ovum makes a dark journey down the Fallopian tube in about seven days. The cells of the zygote divide repeatedly, growing smaller through the morula and the blastula stage. Then in the gastrula stage, the cell mass begins to enlarge and DNA synthesis proceeds rapidly. Little is known about the influence of local tubal environment which is responsible for the selection, rejection or alteration of the genetic potential at this stage.

The early embryo is especially sensitive to ionizing radiation at this early stage. Therefore it would behoove the radiologist to consider the phase of the menstrual cycle when x-raying women of childbearing age. The first week after the onset of the menstrual period would be the safest time for abdominal radiation procedures. Recent work indicates that ovulation not infrequently occurs only ten days after the onset of menstruation.[12]

3. Implantation

The factors governing the site of implantation are unknown. An hormonal imbalance may result in an endometrium unprepared to receive the embryo. In the mouse Russell has demonstrated that the syncitial layers of the placenta are non-antigenic.[13] Therefore, one might assume this new homograft would not be rejected. However, overgrowth or undergrowth of the syncytiotrophoblast may influence the continuing of this genetic potential.

4. Through the 14th Week of Fetal Life from the Onset of the Last Menstrual Period

This is the period when the cellular organization into body form (morphogenesis), cellular specialization in structure and function (histogensis), tissue combination into definite organs (organogensis), and the early stages of functional adaption and correlation (integration) take place.

it is a period of great hazard for the genetic potential. Hertig and Rock have examined the uterus of women of proven fertility within three weeks of known insemination and concluded that one-third showed no signs of pregnancy, one-third had lost the embyro by resorption or abortion, and one-third had the beginning of a normal pregnancy.[14] These are the overall results from unknown causes.

Following an Australian epidemic of rubella in 1940, Gregg first observed the association between maternal rubella and certain congenital defects.[15] Rubella has been shown to terminate genetic potential both in terms of fetal death and increased infant mortality under the age of two.[16] It also has been shown to alter genetic potential by causing malformations among live born children. This influence has been estimated to be as high as 47 per cent in the first lunar month, 22 per cent in the second lunar month, 7 per cent in the third lunar month, and 6 per cent in the fourth lunar month.[17] The more subtle alterations, such as mental retardation and dental anomalies, are not always obvious in early life. The genetic potential in approximately 30 per cent of these children is altered to produce some auditory deficits.[18] Similar effects from other viral infections have not been documented.

Folic acid antagonists, such as aminopterin, also will cause an increase in fetal death in association with congenital malformations. Similar devastating effects recently have been observed with thalidomide.[19] The most crucial period was apparently the sixth and seventh weeks from the onset of the last menstrual period.[20] The mechanism resulting in the timing, the quantity, and the quality of the effect produced by this drug remains a mystery. Its solution will be a great advance in our understanding of teratological mechanisms.

Little is known concerning the effects of ionizing radiation on early development in the human.[21] Rugh has drawn analogies with rodent experimentation and concluded that there was a great hazard of eliminating or altering the genetic potential in these early weeks.[22]

Maternal bleeding during these early weeks is known to be associated with the termination of the genetic potential. Alteration in the form of congenital anomalies or delayed problems of intelligence, etc. are much more difficult to ascertain. One observer[23] believes that vaginal bleeding during the first 12 weeks is not associated with an increase of abnormalities at term.

5. 15th through 27th Week of Fetal Life

The first eight weeks of this period see a decreasing rate of genetic potential loss in the form of fetal death.[1] Moreover, if the embryo is well implanted in the uterine wall, the placenta firmly established in its appropriate location, and organogenesis has proceeded normally, the next five weeks provide little danger. Serious maternal infections, such as poliomyelitis, and severe abdominal trauma may cause fetal death. Fetal radiation at this time may possibly be associated with myelogenous leukemia in childhood as a delayed modification of genetic potential. This is an extremely rare association. Maternal diabetes and thyroid abnormalities must be kept under close medical supervision.

6. 28th Week to Conclusion of Fetal Life

If fetal life is terminated prematurely, this presents many hazards to the genetic potential. Neonatal death rates are greatly increased.[1] The delayed alteration of genetic potential as illustrated by intellectual and neurological deficits may be as high as 25 per cent.[24, 25] Prematurity appears to be the most common denominator in cerebral palsy.

Placentology is a new field. The physiologic and biochemical aspects of the placenta are not well understood. Even in normal pregnancies, the longer the duration the less efficient the placenta is. The mechanical complications of early separation, abruptio placenta, and placental infarctions are ever present hazards.

Immunological incomptabilities, such as the Rh and ABO factors causing erythroblastosis, must be closely followed.[26] By special staining technique, maternal white cells have been demonstrated in fetal blood.[27] This is another source of incompatability, or possibly we are all mosaics with cell lines derived from our mothers as well as our own unique genome.

The toxemias of pregnancy are another hazard to fetal life. These conditions have resisted the efforts of many investigators to unravel the basic cause and effect mechanisms. Treatment is still empiric.

7. **Birth—The Great Divide**

This is a period when much can be learned to improve the hazards to life. Competent, intelligent, sympathetic observation of a woman in labor is a most important safeguard. Recorded conversations with women after delivery indicate that the lack of a constant attendant during labor was seriously felt. Depressant sedative drugs which may cause postnatal difficulties are not a substitute for personnel shortages, or lack of interest. Continuous monitoring of the fetal heart is now available as a research tool. Short of this, auscultation of the fetal heart after EVERY contraction is satisfactory. Frequent observation of the perineum for meconium stained amniotic fluid, a prolapsed cord, or excessively bloody show will provide reliable warning of fetal difficulty, necessitating immediate obstetric judgment. A mother's report of no fetal activity or excessive fetal activity must be weighed seriously.

Uterine inertia is usually synonymous with cephalopelvic disproportion. The longer the labor, followed by caesarean section, the higher the infant mortality. Precipitous delivery of a premature infant is accompanied frequently by intracranial hemorrhage. Long periods of asphyxia result in widespread punctate hemorrhages with a lethal or damaging effect to the genetic potential. Respiratory obstruction in the mother is less likely if her stomach is empty, particularly empty of solid food, when she goes into labor. Severe hypotension may be due to retroplacental hemorrhage, the combined effect of depressive drugs, or to overdose of regional anesthetic agents.

Damage from obstetrical trauma has decreased almost to the vanishing point over the past twenty years. High forceps are taboo, and and even mid forceps application demand much justification. More data are needed to evaluate the rightful place of the vacuum cup extractor.

C. POSTPARTUM PERIOD

In this stage the genetic potential is no longer a dependent parasite, but has become an independent individual. This is the "cradle to grave" era which has been the prime interest of medical science for many years. Since the first few hours and days are a period of great hazard, as we will limit the discussion to the first 48 hours, with the full realization that many of the effects of previous hazards will not be manifest until later in postpartum life.

The integrity of the newborn baby's respiration, circulation, and nervous system should be checked immediately after birth. If respiration is inadequate, the airway must be cleared immediately and the lungs ventilated. If the baby is pale and the circulation is poor, there may have been hemorrhage into the placenta thus requiring a replacement transfusion. In situations where erythroblastosis is suspected, an immediate examination of cord blood for blood group, Rh factor and Coombs' test may lead to a prompt exchange transfusion. Lack of improvement in the newborn Apgar score[28] should promote a search for hidden anomalies, such as diaphragmatic hernia or pneumothorax. Mongolism or amyotonia may present a poorly responsive nervous system. Karyotype studies from cultures of cord blood white cells may reveal unexpected chromosome aberrations. Levels of phenylalanine or galactose may be obtained from heel blood samples as a screen for mental deficiency. The umbilical cord might be observed for the occurrence of a single umbilical artery which is often associated with an increase in malformations.

Respiratory distress is a leading cause of early death. Earnest effort should be made to diagnose the cause so that one might apply appropriate therapy. There still, however, remains a large group of infants with respiratory distress in whom the cause cannot be determined. This group is sometimes referred to as the respiratory distress syndrome. The part artificial ventilators, aerosol sprays, drug therapy, extracorporeal circulation, or intravenous fluids and acid base therapy, play in the treatment of this syndrome have not been completely worked out.

The etiology of kernicterus which occurs during this period also eludes us. Its relationship to hyperbilirubinemia as a result of Rh erythroblastosis is well known. However, its association with hyperbilirubinemia from other causes has not been as well established, and it is known to have occurred in prematures with hyperbilirubinemia.[29 30]

These are some of the known hazards to the continuity of genetic potential. There is an unfathomable preconception loss of genetic potential. Periconception loss is estimated to be about two-thirds.[14] Roughly ten per cent or more of the genetic potential which survives conception will be eliminated during fetal life. Another two per cent or so will not make it through the neonatal period. From there on in, the life insurance companies will give you the odds.

> "Believing as I do that man in the distant future will be a far more perfect creature than he now is, it is an intolerable thought that he and all other sentient beings are doomed to complete annihilation after such long-continued slow progress. To those who fully admit the immortality of the human soul, the destruction of our world will not appear so dreadful." — Charles Darwin
> (1809-1882)

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Editorial Page . . .

POISONINGS, ACCIDENTAL & OTHERWISE

Accidents are the commonest cause of death in the relatively young Alaskan population. Poisoning from accidental ingestion is a major cause of morbidity and to some extent mortality in the childhood age group. It is estimated that there are 250,000 potentially toxic compounds available to the average American today and to further complicate this problem, nearly 40,000 of these change either their label or their ingredients yearly. To help disseminate information about some of these chemical poisonings, it is planned to report case histories of these incidents in each of the forthcoming issues of **Alaska Medicine.** It would be appreciated if a brief resume of any unusual ingestion in either child or adult be forwarded to Dr. Elizabeth Tower, Editor of **Alaska Medicine,** 610 Second Avenue, Anchorage.

At present there are two official poison centers in operation in Alaska—in Anchorage at the Alaska Native Health Hospital and in Fairbanks at the Northward Drug Store. The Central Poison Control Center in Washington, D. C., supplies these centers monthly with a current listing of new products. Previously, incidences of poisoning with salicylates, the tranquilizers, and the effect of maternal medication on the newborn infant have been reported. Elsewhere in this issue medicinally used seal oil is postulated as a possible etiological agent in chronic pulmonary disease among the native population.

INCIDENCE I

Toxic Agent	Age	Sex
Bug Killer (containing lindane, a gamma isomer of benzene hexachloride). Trade name: Bug-Tab Tablets.	6 yrs	Female

This six year old girl, apparently in fun, took approximately one and a half tablets of Bug-Tab during a "tea party" approximately six hours before she had the first of a series of convulsions. The child fell from bed and was taken to her family physician in Kenai who noted a bizarre type of seizure with tonic clonic movements, staring, disorientation, and extra-pyramidal signs with associated vomiting. The child was flown to Anchorage as an emergency by CAP plane as a possible head injury. On arrival she appeared drowsy and disoriented, but with good vital signs. The father called approximately eight hours after hospital admission of the child to state that he had learned from her sister that she had taken a toxic agent. Physical examination and neurological examination were entirely clear other than for some weakness of the left sixth cranial nerve, right lower face and a positive left Babinski.

Laboratory studies included a clear lumbar puncture. Urinalysis was negative. Blood count revealed a hematocrit of 38%; a hemoglobin of 12 grams; and a white count of 8,350 with 74 segmented forms, 4 eosinophils, 20 lymphocytes, and 2 monocytes. A transaminase was normal at 32 milligrams %.

This drug is known to cause gastrointestinal symptoms, severe convulsions with extra-pyriamidal signs, and may lead to respiratory and cardiovascular collapse and death. There is no known antidote except to control the seizures and remove the individual from exposure. Apparently, there is some danger of liver damage and bone marrow depression. This child was discharged home in thirty-six hours apparently well and has had no further convulsive episodes during a three months period. She received no treatment other than observation as the seizures had subsided and the type of toxin ingested was not known on admission.

Emergency treatment if ingestion is recognized, should consist of gastric lavage with 2 to 4 liters of tap water or emesis followed by catharsis with one ounce of sodium sulphate in 250 cc's of water. The skin should be scrubbed with soap and water to remove excessive skin contamination. Artificial respiration with oxygen may be necessary for severe respiratory depression. There is no specific antidote. Anticonvulsants should be used as necesary and calcium glucinate 10% to 10 cc's I.V. every four to six hours as a non-specific cellular protectant is advised. Stimulants such as Epinephrine should not be given. The prognosis for complete recovery is fairly good unless the convulsions are severe or unless this agent is taken in an organic solvent which may cause progression of symptoms to pulmonary edema and vascular collapse.

—Helen S. Whaley, M.D.

Alaska Deparment of Health News

EDWIN O. WICKS, M.D., Director of Public Health

Dr. Wicks

Scientific and technical exhibits prepared by Division Personnel for the 18th annual meeting of ASMA were also displayed at conventions of Alaska Nurses, Dentists, AAAS, and by local health units at the Fairs in Homer, Palmer and Fairbanks. Health subjects covered are fluorescent microscopy, civil defense emergency hospitals, deaths in Alaska by violent causes, and communicable disease incidence featuring tuberculosis and gonorrhea.

* * * * *

Legislative appropriation for public health activities in FY 1964 was 2.92 million dollars, half from State funds, half from Federal grants and contracts, and a tiny $86,000 from local governments and communities. Newly obtained technical assistance (loan of PHS specialists) and scientific grants will push the total expenditure past 3.0 million. Rough program categories will run this way:

Maternal-Child Health	$402,000
Public Health Nursing	$883,500
Tuberculosis Control	$399,800
Environmental Health	$498,000
Laboratories	$304,200
Communicable Disease Control	$ 39,000
Health Education	$ 50,900
Professional Administration	$298,000

* * * * *

Route 666 is the Alaskan highway to health information and knowledge. It represents the number of 16 mm. films now circulating the State bringing current facts and messages to anybody having access to a sound projector, a few watts and a darkout shelter. The subjects cover nearly every pertinent matter of physical and mental health and additions are continously made by purchase, loan from private and governmental sources, or contributions from voluntary agencies and associations. Copies of the complete catalog can be obtained by simple request to the ADH&W Film Library, Juneau. Viewers last year totaled more than our entire population. Particularly interesting to physicians is the trend in recent releases toward "impact" and scrupulous attention to realistic detail, reflecting TV and feature movie techniques.

* * * * *

Consultant Chief of Tuberculosis Control Dr. F. J. Phillips predicts that success of the increasing effort to find new active cases and bird-dog known ones will hospitalize enough Alaskans in the next year to run this budget into the red around $25,000. If this occurs it will result in the first request for a supplemental appropriation from the Division of Public Health since statehood. Fortunately the Legislature, Governor, State Medical Association and public at large clearly support the TB Control program and will accept the added costs in order to drive toward eradication of the disease. Dr. Phillips believes that heightened alertness of private and agency practitioners in examining patients, full utilization of tuberculin testing, and more intensive epidemiologic efforts of State health personnel account for the rise in newly discovered infections rather than a true increase in incidence.

* * * * *

Lloyd Morley, long-time health worker in Alaska and most recently known to physicians and hospitals for his leadership of the Hill-Burton activities and institution licensure section, has taken over general administration duties for the Division of Public Health. He will correlate work of consultants, other State Departments, and Division staff as well as carry the burden of managing Federal grant programs.

* * * * *

Clam-digging for research purposes on "mussel poisoning" yields continuing uneasiness over risks on Alaskan beaches. A June harvest of toxin was twice as potent as the next highest find in the past 30 years and cases are being encountered by southeastern physicians in their daily practice. A mysterious alkaloidal agent, the toxin induces peripheral and CNS aberrations which can reach total collapse proportions. Supportive therapy may need to be herculean.

* * * * *

Conferences with presidents of the State's two institutions of higher learning produced information which is in essential agreement with views of many individual physicians on medcal and allied science education. Briefly, it appears that Alaska will not be able to support financially or clinically a medical school until the population reaches 1.5 million. A unique and enlarging role in Arctic graduate medicine is visualized for the University, while Alaska Methodist is intensively studying baccalaureate programs in nursing, biology and chemistry. These considerations and associate data were presented to the WICHE Forum on Medical Education at San Francisco in late May. Both Alaskan colleges expressed a strong hope that local medical societies would engage heavily in orienting high school students to careers in the life sciences, most departures to other fields being made about age 15.

* * * * *

Cooperation from physicians, dentists and other operators of x-ray equipment insures success of early plans of the State's Unit of Radiological Health. Also of great help has been the interest and effort of Milk Producers who had correctly foreseen last fall's high rise in fallout and were ready to switch herds to storage feeds ahead of public uproar. Surveillance instruments to monitor marine and land-life burdens and the accumulation of background data are next goals for the Division of Public Health with cooperation of the University and numerous federal agencies.

* * * * *

Provision of the very elements of environmental hygiene, water supply and waste disposal systems remains the State's greatest need in this aspect of health. Projections of design capacities for communities in which such work is necessary and can be done today indicates some $17 million would be spent if it were available. Bonding potentials seriously limit all but one or two cities from constructing adequate facilities, although some work progresses in Sitka, Juneau, Kenai, Dillingham, Bethel, Anchorage, Palmer, North Pole, Fairbanks and Nome. Rudimentary efforts are being made by the PHS for native villages but progress is slow because labor must be contributed locally. The Office of Rural Development is expected to sponsor similar projects in cooperation with engineers, sanitarians and aides of this Division in remote areas after July 1.

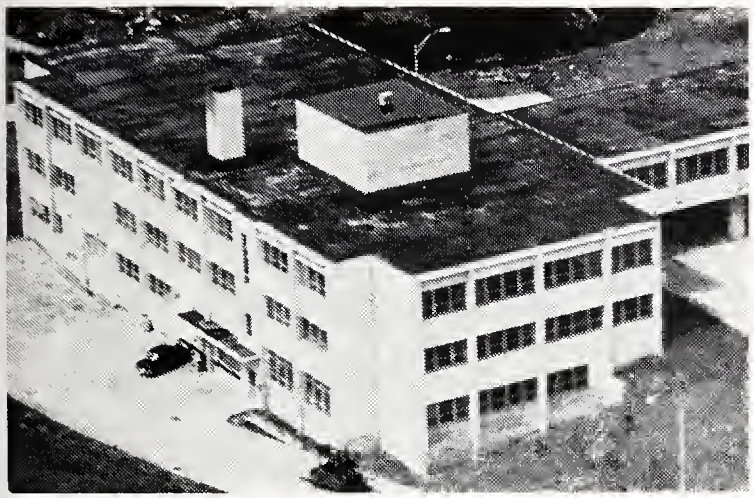
U. S. P. H. S. News

Dr. Holman R. Wherritt has assumed the position of Alaska Native Health Area Director.

New appointments to the staff of the Anchorage hospital include Dr. Walter Johnson, Acting Chief of the Medical Service. Dr. Johnson formerly served as a USPHS physician at the Bethel hospital. Dr. Albert Bloomstrom is the new Anesthesiologist, Dr. D. Gilbert Wright the new Oral Surgeon, and Dr. William Buchanan the new Ophthamologist. New general staff members include Dr. Frederick Banfield, Dr. Paul Davidson, Dr. Glenn Hisrich, and Dr. Richard Light. Dr. Martha Wilson is Acting MOC.

New MOCs at other hospitals include: Dr. Robert Russell, MOC at Barrow; Dr. Roger Bauman, MOC at Annette Island; Dr. Robert Fortuine, MOC at Kanakanak; Dr. Hugh Johnston, MOC at Tanana; and Dr. Robert Schmitt, MOC at Juneau. Dr. Frank Keefer continues as MOC at Bethel and Dr. Thomas Harrison as MOC at Kotzebue. Dr. George Wagnon, former Kanakanak MOC, becomes MOC at Mt. Edgecumbe. New Staff Physicians include Drs. Daniel O'Connell and Carl Denny at Bethel, Dr. Thomas Moylan at Kanakanak, and Dr. John Lunas at Mt. Edgecumbe. Dr. George Langenbaugh is the new Chief of Surgery and Dr. Eugene Gaenslen the Chief of Medicine at Mt. Edgecumbe. Physicians previously with the USPHS in Alaska but changing location are Dr. Richard Light moving to Anchorage, Dr. William Mentzer and Robert Takach to Kotzebue, Dr. William Degelman to Tanana, and Drs. James Brubaker and James Justice to Mt. Edgecumbe.

President's Page . . .



Ketchikan General Hospital

(The following are comments made by Dr. Ralph Carr at the August 11 dedication of the Ketchikan General Hospital.)

Distinguished guests, ladies and gentlemen:

I was asked to speak today as President of the Alaska State Medical Association, and I bring you greetings from that group.

When they had an earthquake at Stanford University some years ago, a statue of Plato tumbled head first into the pavement. The Dean of Stanford remarked that he was accustomed to thinking of Plato in the abstract, but never in the concrete. Conversely to the Dean, when I was asked to speak today, representing the Alaska State Medical Association, I tried to adjust my thinking from the day to day practice of medicine to the overall picture of medicine in Ketchikan from the turn of the century. There have been two previous hospital phases in Ketchikan—from 1903 to 1923, twenty years; and from 1923-1963, forty years. Now in 1963 we are at the threshold of a third phase.

The first hospital phase began about 1903 when Ketchikan was pretty much of a pioneer community with dirt paths and wooden walkways. The present Hopkins Alley was THE **FRONT** STREET. Mission Street was so-named because of the St. John's Episcopal Mission. In our office storeroom we have an American Sterilizer Company steam pressure sterilizer dating from that time, and listed on company records as for the St. John's Episcopal Hospital. The last time I checked, it had been made 225,000 sterilizers ago by the American Sterilizer Company.

The St. John's Church Hospital on Mission Street was, as you know, **named** the Arthur Yates Memorial Hospital, and is the building now housing the Alaska Specialties. Emory Tobin's present office was the old operating room there. When I came to Ketchikan the Arthur Yates Memorial Hospital was still decorated with framed pictures of passenger steamships on the Alaska run, possibly as a gesture to the seamen hospitalized there under the U. S. Public Health Service.

The Ketchikan General Hospital on Bawden Street opened its doors in 1923. It too had its primitive beginnings. There was an episode before my arrival in 1940 when Dr. Romaldo Vinton Ellis, and his associate Dr. Benny Rones tried to take an x-ray on a portable x-ray machine known to have a short circuit. Before Dr. Ellis had taken his hands off the machine, Dr. Rones thoughtlessly pressed the button, and the jolt of electricity knocked Dr. Ellis to the floor. Dr. Rones reportedly ran about wringing his hands crying, "I've killed him, I've killed him." But Dr. Ellis came to, crawled into a hospital bed for a day and a half, and was soon all right. Dr. Ellis, by the way, gave the old Ketchikan General Hospital the major surgery table for the major surgery room, which, during World War II became and still is the Minor Surgery room. The tiny plaster room of the old Ketchikan General Hospital was formerly the Delivery Room, and I recall that female relatives of women in labor would occasionally walk in, chat, and walk out again.

The Government during World War II built the improved obstetric Delivery Room on the 2nd floor of the old Ketchikan General Hospital, added an operating room on the 3rd, and built the Nurses Home, Laundry, and Boiler Room, besides adding to each wing. Now in 1963 we're entering the 3rd hospital phase with this fine new building near the Carlanna District. It has been built at the end of a 25 year period that has shown a greater advance in Scientific Medicine than in the preceding 250 years. Science is dominant, but I think that the personal qualities of the doctor count just as much, if not more, than ever before.

And whom should we think of at this time of dedication? Of the early Ketchikan doctors such as Story, Carruthers, the three Brothers Meyer, of Beeson, Mustard, Ellis, and Henry Turner, to name some (though not in chronological order). We should think of every nurse, Sister, nurse aide, hospital Guild member, members of the Red Cross Chapter, and each Gray Lady, the various Clergymen, and members of the sick-visiting committees of the Fraternal Orders and Women's Organizations, of anyone and everyone who has tried to improve the Health and Happiness of this Community. The Seeds of Faith and Goodness never die.

ALASKA STATE MEDICAL ASSOCIATION COMMITTEES—1963-64

Emergency Care—Civil Defense: Keers, Chairman, R. Smith, Colberg, Reiderer, Isaak, T. Shohl, Harrell, Wicks, Heavrin, Leih

Occupational Health: T. M. Moore, Chairman, Ormond, R. Smith, Marrow, Storrs

Historical: Browning, Chairman, Spencer, Whitehead, Chenoweth, Fritz, Haggland

Mental Health: Langdon, Chairman, Spencer, Schneider, Billings, H. Whaley, Crawford, Meyer, Homer Ray, Deisher

Constitution & By-Laws Committee: R. Wilson, Chairman, J. Ribar, R. Whaley, E. Stanley Ray

Trauma: T. M. Moore, Chairman, Storrs, Mead, Hillman, Hale, Reiderer, J. A. Wilson, Isaak, R. Smith

Voluntary Health Organizations: P. Smith, Chairman, H. Whaley, Winton, Tatum, Akiyama

Tumor Registry: T. Shohl, Chairman, Coin, J. A. Wilson, Drake Joseph Johnson, Beirne

Resolutions: A. N. Wilson, Chairman, R. Wilson, Shuler, Cramer, Coon, Davis

Medical Problems of Outlying Communities: Schirmer, Chairman, Fenstermacher, Davis, Pinneo, Keers, Gaede, Chapman, Sandberg, Deisher, R. Smith, Adams, Fenger

School Health: J. Tower, Chairman, Shuler, Deely, Langston, Salazar, Gibson, Wicks, Ormond

Vocational Rehabilitation: Whitehead, Chairman, Ormond, Fenstermacher, Storrs, H. Ray, H. Whaley, G. Field

Medical Practice Act (Legislative): Mills, Chairman, Browning, Carr, Wilkins, Shelton, Koeniger, R. Whaley, Ribar, Chenoweth, Akiyama, P. Moore, A. N. Wilson, R. H. Johnson, M. Fritz, Haggland, Lundquist

Public Health: Kettelkamp, Chairman, H. Whaley, Langston, J. Tower, Kiester, Zartman, Gibson, Tatum, Phillips

Arrangements: Carr, Chairman, Salazar, Winton, A. N. Wilson, J. A. Wilson, P. Smith, Cramer

Alaska Medicine Editorial Board—H. Wilde (1967)
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Minutes of the 18th Annual Meeting of the ALASKA STATE MEDICAL ASSOCIATION

ANCHORAGE, ALASKA

MAY 29, 30, 30, JUNE 1, 1963

MEMBERS ATTENDING

ANCHORAGE — R. E. Harrell, Robert B. Wilkins, Wm. J. Mills Jr., Joseph H. Shelton, Glenn Crawford, Robert Billings, James Fitzpatrick, James W. Coin, Ted Shohl, Wm. Rader, Rosalie Shohl, Don Val Langston, W. C. Matthews, George E. Hale, Alan Homay, Peter Koeniger, Virginia Wright, Frank Montmorency, Perry A. Mead, Gloria Park, James O'Malley, Charlie Chenoweth, Calvin Johnson, Winthrop Fish, Francis J. Phillips, John Tower, Chi Mei Chao, Elizabeth Tower, Louise Ormond, Thomas R. McGowan, Rudy Leong, Helen Whaley, Robert Whaley, Royce H. Morgan, Milo H. Fritz, Thomas Keister, Mahlon Shoff, George Wichman, A. Claire Renn, Donald Kettelkamp, Duane L. Drake, Vernon A. Cates, Harold Bartko, Michael F. Beirne, Nancy Sydnam, Rodman Wilson, J. Ray Langdon.

BETHEL—Harriet J. Schirmer.

CHUGIAK—Marshall Simpson.

CORDOVA—W. John Chapman.

DILLINGHAM—John E. Libby.

FAIRBANKS—James Lundquist, Henry G. Storrs, Joseph Ribar, Paul B. Haggland, George Clark, C. William Bugh, Nicholas Deely, Donald E. Tatum.

GLENALLEN—Chester L. Schneider.

JUNEAU—Henry Akiyama, Grace E. Field, Levi M. Browning, E. Stanley Ray, Edwin O. Wicks.

KETCHIKAN—Dwight L. Cramer, Ralph W. Carr.

KODIAK—J. Bruce Keers, R. Holmes Johnson.

NASHVILLE, TENNESSEE—John A. Barrow, III.

NOME—Robert E. Fenstermacher.

SAND POINT—Carl E. Sandberg.

SEWARD—Joseph B. Deisher.

SITKA—Philip Moore, Edward D. Spencer.

SOLDOTNA—Paul G. Isaaks, Elmer E. Gaede.

SPENARD—William O. Rabourn.

WEDNESDAY, MAY 29, 1963

The 18th Annual Meeting of the Alaska State Medical Association was called to order at 9:15 A.M. Wednesday, May 29, 1963, at the Anchorage-Westward Hotel, Anchorage, Alaska, by William J. Mills Jr., President.

Dr. Chester Schneider of Glenallen gave an Invocation.

Anchorage Mayor George Sharrock welcomed the Association members and guests, expressing pleasure at having the Convention held in Anchorage and offering the facilities of the city to those attending.

The Minutes of the 1962 Convention were presented by the Secretary-Treasurer, Dr. Robert Wilkins. It was noted that the official Minutes were identical to the Minutes as printed in ALASKA MEDICINE, Volume IV, No. 3, dated September, 1962. On a motion by Dr. Storrs, seconded by Dr. Lundquist, the Minutes were approved as presented.

The Secretary-Treasurer then presented separately the financial statements of the Alaska State Medical Association and of ALASKA MEDICINE, prepared with the assistance of Peat, Marwick, Mitchell & Company, Certified Public Accountants. On a motion by Dr. J. Ray Langdon, duly seconded, the financial report was unanimously approved.

President Mills then called for the report of the Nominating Committee, consisting of Drs. Joseph Shelton, Chairman, Joseph Ribar, R. Holmes Johnson and Edward D. Spencer. The Committee presented the following nominations: President-Elect, Donald E. Tatum; Vice-President, Chester Schneider; Secretary-Treasurer, Robert B. Wilkins; Councilor, South Central Area, Bruce Keers, Anchorage Area, A. S. Walkowski; Delegate to the American Medical Association, Joseph Ribar; Alternate Delegate to the American Medical Association, Robert Whaley.

Further consideration of nominations was announced for the following day, as called for by the By-Laws.

The meeting was recessed briefly to prepare for the joint session of ASMA members with the Subcommittee of the Legislative Council holding a hearing for recommendations from the medical profession on legislative matters.

On reconvening the meeting for the joint session, President William J. Mills presented an address, tracing the ASMA legislative activities relating to the medical profession from 1947 to 1963. He then turned the meeting over to the Honorable Bruce Kendall of Anchorage, Speaker of the House of the Alaska Legislature, and Chairman of the Legislative Council. Mr. Kendall then introduced the participating legislators and legislative council staff members: Sen. Robert J. McNealy, Fairbanks; Rep. James C. Parsons, Anchorage; John C. Doyle, Executive Director; Durell Douthit, Research Counsel. Representatives Mike Gravel and Keith Miller of Anchorage also sat with the Council.

Dr. Joseph Shelton, Chairman of the ASMA Committee for the revision of the Medical Practice Act, was the first witness to testify. Dr. Shelton pointed to the need of a comprehensive revision of the law on medical practice, noting that there is no provision for licensing osteopaths, podiatrists (chiropodists), opticians, psychologists, X-ray technicians, and midwives. He also noted that the law was deficient in descriptive definitions of the various healing arts and that the agglomeration of laws developed over the years were in conflict.

Dr. Glenn Crawford, Chairman of the ASMA Legislative Committee, reported that the Association concurred in the recommendations reported by Dr. Shelton. Dr. Crawford reported that the Association was concerned over CSSB #20 (occupational and licensing boards), especially that portion that would allow the appointment of a Board of Examiners in the basic sciences and a State Medical Board by the Governor without the necessity of including even one member of the medical profession. Dr. Crawford reported that the Association had retained Mr. Frank Doogan, Juneau Attorney, as ASMA Legislative Advisor, and that the Association's future stand on CSSB #20 would depend on the results of Mr. Doogan's study and advice regarding this Bill. Dr. Crawford also reported that the Association endorsed the following carry-over Bills:

House Bill No. 20—Laboratory Technicians.

House Bill No. 70—Planned Parenthood Information.
House Bill No. 149—Mental Health Account in General Fund.
House Bill No. 131—Professional Corporations.
House Bill No. 185—Hazardous Substances.
House Bill No. 28—Safety Seat Belts.

Dr. J. Ray Langdon, ASMA Mental Health Committee Chairman, urged that the Legislature wait to appropriate funds for any mental facility capital expansion until a survey of needs is made by the State with federal funds now available. Dr. Langdon also suggested resistance to pressure for use of Alaska Psychiatric Institute for untreatable cases (chronic mental illness, etcetera). He noted that there is no state plan yet for the mentally retarded. He said that there was noticeable improvement in the schedule of salaries paid by the state to mental health personnel but more is needed. He said he felt that the Division of Mental Health should be made a separate department eventually.

Dr. Peter Koeniger, Chairman of the Committee on Adoptions of the Anchorage Medical Society recommended that a licensed physician examine each child offered for adoption to check its suitability for adoption in order to protect the child and the adoptive parents. Final adoption action should not take place until after six months of placement with adoptive parents. Another medical examination would be given at that time. Dr. Koeniger said that the group opposed any law which would require that all adoptions be handled through a public agency. Both public and private adoptions should be permitted with the court having discretionary powers in requiring a review by social agencies. The Anchorage recommendations have not yet but will be presented to the state society for endorsement.

Dr. Joseph Ribar endorsed the plan for revision of the Medical Practice Act, stressing the need to determine the competence of those practicing the healing arts to protect the public interests. He also asked for a clarification of the policy and procedure attending the distribution of proceeds from state mental health lands.

Dr. Robert Wilkins, ASMA Secretary, reported that it is the plan of the Association to have the legislative committee, with the assistance of its counsel, Frank M. Doogan of Juneau, prepare the Association's recommendations on changes in the medical practice law. Mr. Doyle outlined the needs of the Legislative Council and Legislature as regards suggested legislation. Dr. Wilkins said that it was the Association's intention to have its recommendations prepared in the form of suggested legislation rather than just ideas. The suggested bill, with an analysis of contents and intent, will be submitted to the Legislative Council office by November 1. This will allow time for staff review and consultation with the Association's counsel before the proposal is considered by the Legislative Council for reference to the Legislature. Senator McNealy pointed out the importance of having a well-prepared proposal, the chances of which will be enhanced by Council sponsorship.

Dr. Virginia Wright, Anchorage Psychiatrist, presented a "Minority Report" stating that she felt that the Alaska Psychiatric Institute should not be restricted for acute patients, but used for all the mentally ill of Alaska, supplemented by clinics in three population centers. She stated that she felt that chronic cases should be treated and kept in the State.

Dr. William Rader, Anchorage Psychiatrist, endorsed the report of Dr. Langdon on use of mental health facilities for only acute cases, but pointed to the need for facilities for other cases, particularly for children. He noted that the present state facilities do not have accommodations for felony cases and these should be provided. He also asked for revision of the legal test for insanity. He declared the use of the McNaughton rule archaic and unjust and asked for an adaptation of the Durham rule. Senator McNealy and Representative Parsons questioned the need for a change which had been adopted in only one jurisdiction. Dr. Rader also stated that, under present law, a man must be a danger to himself or his community *and* must be in need of treatment before he may be committed to a mental institution without his consent. Dr. Rader suggested that the first condition should be omitted so that all persons in need of treatment, whether dangerous or not, could be committed without consent.

The Chairman, Representative Kendall, then invited anyone with questions to come forward and consult with the Legislative Council and they would remain available for this purpose at the close of the meeting. The meeting was then recessed until the following day.

Thursday, May 30th, 1963

The meeting was called to order at 8:15 A.M. by President William J. Mills. Dr. Mills announced that the Resolutions Committee was comprised of Doctors Rodman Wilson, Chairman, Henry G. Storrs, Dwight L. Cramer, Joseph B. Deisher, Peter Koeniger, and Robert Whaley.

Dr. Mills then called for reports of committees:

Tumor Board: Dr. Theodore Shohl, Chairman, reported that there had been considerable activity of this committee. He reported that a Tumor Registry had been instituted in Fairbanks under the guidance of Dr. Henry Storrs and had been functioning since February 1963. Plans in the Anchorage area for a Tumor Registry were far advanced, and have awaited final completion due to the development of the new Presbyterian Hospital in the area and the completions of laboratory arrangements at Providence Hospital. It was Dr. Shohl's impression that a Tumor Board would be operating before the end of the year at both of these hospitals. In addition, the Alaska Native Hospital in Anchorage will join the plan probably by the end of the year. Dr. T. M. Moore has been actively working on this program in Sitka. Funds to coordinate the reporting at a state level will be available through the American Cancer Society. The report was duly accepted.

Occupational Health Committee: Dr . George Wichman, submitted a written report indicating that this committee had investigated the possibility of changing the presently used compensation forms, and that after consultation with numerous physicians and after careful consideration, no recommendation for a change was made.

Committee for Promotion of Self-Sufficiency of Alaskan Natives: Dr. Robert Whaley, Chairman, gave an oral report, saying that most of the work had been done by Dr. R. Holmes Johnson of Kodiak, and he reported that there was a ground swell of interest in this committee which is non-medical in a sense, to encourage the native people to become first class citizens, and to minimize the discrimination which is apparent. Dr. Johnson supplemented Dr. Whaley's remarks. The committee report was duly accepted.

Committee to Study the Revision of the Medical Practice Act: Dr. Joseph Shelton, Chairman, stated that his report had been given the previous day at the Legislative Council hearing, and that his recommendations are being incorporated in a resolution to be drafted by the Resolutions Committee.

Committee for Study of Fee Schedules, Contracts, and Relative Values: Dr. Robert Wilkins, Chairman, reported that no definite action had been taken by this committee during the year. He reported that the Sitka-Mt. Edgecumbe Medical Society had gone on record as favoring maintenance of a recommended State Fee Schedule. It was recommended by Dr. Wilkins that the Fee Schedule and contract with the Veterans' Administration be changed by altering certain fees alloted for surgical procedures, as requested in a letter from Dr. William Whitehead of Juneau. On a motion by Dr. Robert Whaley, seconded by Dr. Spencer, the society voted to continue fee schedules now in force, and that the Secretary-Treasurer proceed to negotiate with the Veterans' Administration for the recommended changes in the Fee Schedule.

After a brief recess, Dr. Mills introduced the Panel of representatives from state and federal agencies, consisting of Col. Levi Browning, M.D., Commissioner, Alaska Department of Health and Welfare, Juneau; Dr. Grace E. Field, Clinic Director for Veterans Administration, Juneau; Dr. Holman Wherritt, representing Dr. Kazumi Kasuga, Area Medical Officer, Alaska Native Health Service, U.S.P.H.S., Anchorage; Dr. Edward Wicks, Director of the Division of Public Health, Alaska Department of Health and Welfare, Juneau; Mr. Robert McMillan, representing Mr. Caroll Craft, Director, Alaska Office of Vocational Rehabilitation, Juneau; Dr. Thomas McGowan, Regional Health Officer, Division of Public Health, Anchorage.

Dr. Browning spoke first, stating that he wanted to do whatever he could to help solve the health problems of Alaska, and pointed up his need for help in solving some of these problems.

Dr. Field thanked the physicians for their cooperation with the Veterans' Administration program. She pointed out that her agency operated under laws passed by the U. S. Congress, and that in her opinion a superior service was provided in Alaska. She mentioned possible changes in the Veterans' Program, such as restoration of hospital benefits in private hospitals. A Bill is now before Congress calling for this. She made a plea for a reduction, whenever possible, of drug bills which had become formidable. She cited comparative costs of certain drugs, and suggested the use of generic terms rather than trade names as a possible means of lowering drug bills.

Dr. Wherritt stated that his agency appreciated the cooperation of all of the doctors in the operation of the tremendous ANHS program involving a large segment of the state's population.

Mr. McMillan expressed pleasure with the ability of his agency to provide a more helpful program for its beneficiaries and the medical profession. He reminded those present that his agency was interested in helping the disabled secure employment, and that the agency was expanding into the field of cardiac disease, mental retardation, and mental illness. He cited examples of patients with leg, larynx and heart defects who had returned successfully to their trades or professions through the Vocational Rehabilitation Program.

Dr. Wicks stated that a Radiation Survey is planned for the State, but necessary funds for this were not immediately available.

Discussion ensued on the United States Senate Resolution #29, relating to medical and dental care in remote areas being rendered by ANHS-PHS physicians and dentists. Dr. Wherritt stated that he felt it was not advisable for his agency to provide care for all persons in remote areas except in emergencies. He stated that his agency was pressed and pushed to provide adequate care for the Alaska native beneficaries. He spoke on ANHS eligibility, stating that it is hard to precisely define an American Indian or native. He stated that the present policy is to consider all natives regardless of blood quorum eligible to receive care if they are living in an Indian community as an Indian or native. This makes Indians living in large urban areas, such as New York City, ineligible, as care is otherwise provided. He stated that the ANHS basic responsibility is outlined by an Act of Congress. The agency tries to help the individual and community assume their responsibilities. He stated that the agency in certain cases makes minimal charges to show there is a value in such care.

There was further discussion on the VA Fee Schedule, with questions being directed to Dr. Field. Dr. Wilkins pointed out that certain government agencies arbitrarily used the Veterans Administration Fee Schedule in dealing with members of the Association and other physicians even though the Association has requested these agencies to recognize the ASMA Fee Schedule. It was noted that in several instances, the VA Schedule was limited in format, and that it was inappropriate for the agencies to resort to expediency in this matter. Dr. Don Val Langston, Anchorage pediatrician, particularly noted the deficiency of the VA Schedule in regard to pediatrics. An amended motion was then duly passed authorizing the Executive Committee to negotiate with the various governmental agencies for the use of the ASMA Recommended Fee Schedule whenever possible.

The meeting was recessed at 10:30 A.M.

Friday, May 31st, 1963

The meeting was called to order at 8:00 A.M. by the President, William J. Mills Jr. Election of officers then followed. There was a nomination from the floor for Dr. James A. Lundquist for President-Elect, but he declined the nomination. Dr. Donald E. Tatum was then unanimously elected President-Elect.

Dr. Chester Schneider declined the nomination for Vice-President stating that he would be out of the state for a large portion of the coming year. Dr. Robert Whaley was then nominated for Vice-President and unanimously elected.

There were no additional nominations for Secretary-Treasurer, and Dr. Robert Wilkins was unanimously elected to this office.

The office of councilor for the northern district was declared vacant due to Dr. Tatum's election to the position of President-Elect. Dr. James A. Lundquist was nominated and unanimously elected as councilor for the northern district.

Dr. Glenn Crawford was nominated to the office of Anchorage area councilor, but declined the nomination. A unanimous vote for Dr. A. S. Walkowski for Anchorage area councilor and Dr. Bruce Keers for south central area councilor then occurred. A unanimous vote was then cast for Dr. Joseph Ribar as delegate to the American Medical Association, and Dr. Robert Whaley as alternate AMA delegate.

The Secretary-Treasurer then read the Minutes of the Council meeting held May 28, 1963. On a motion by Dr. Crawford, seconded by Dr. Carr, the Minutes were approved as read. Dr. Langdon moved and Dr. Crawford seconded a motion to endorse the actions and recommendations of the Council, particularly regarding the Medical Practice Act and Professional Code. Motion passed.

Dr. Mills then announced the proposal to combine the positions of Editor-in-Chief and Managing Editor of ALASKA MEDICINE, with Dr. Elizabeth Tower to fill both positions. A meeting of the Editorial Board of ALASKA MEDICINE will be called to consider this proposal.

RESOLUTION XII was then moved for consideration by Dr. Rodman Wilson, Chairman of the Resolutions Committee.*

RESOLUTION XII

(Robert Whaley, M.D.)

RESOLVED, that the Alaska State Medical Association abdicate all responsibility for the collection of dues for the Woman's Auxiliary.

It was moved by Dr. Haggland, seconded by Dr. Deisher that this Resolution be approved. Under discussion, the Secretary-Treasurer pointed out that it had not been practical or feasible to collect the dues for the Woman's Auxiliary, for a variety of reasons. Resolution XII was adopted with one dissenting vote by Dr. Joseph Ribar.

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*Resolutions subsequently adopted are printed in italics

RESOLUTION IX was then presented by the Resoolutions Committee Chairman.

RESOLUTION IX

(ROBERT B. WILKINS, M.D.)

WHEREAS after a careful study of medical fees throughout Alaska over a period of years was made by the Alaska State Medical Association and crystallized in the form of a schedule known as the ASMA Recommended Average Fee Schedule, and

WHEREAS at the 1960 ASMA Convention this fee schedule and other recommendations of the fee schedule committee regarding contracts with government agencies was formally adopted, and again adopted at the 1961 ASMA convention, and

WHEREAS the ASMA's efforts to negotiate this fee schedule and related contract recommendations with various government agencies have not come to fruitation, and

WHEREAS the existing contracts with certain government agencies or the total absence of any contract with other agencies are both inappropriate and in many instances inequitable,

THEREFORE BE IT RESOLVED that the ASMA again endorses the recommendations of the 1960 Fee Schedule Committee and again attempt to negotiate these recommendations with the agencies concerned.

Then Dr. Storrs moved and Dr. Carr seconded a motion to adopt Resolution XI. On a motion by Dr. R. Holmes Johnson, seconded by Dr. Fish, the Resolution was amended by deleting the last 10 words and substituting the phrase *"authorize the Council to negotiate these recommendations with the agencies concerned."* The amended resolution was then unanimously adopted.

Dr. Rodman Wilson then presented and moved for the adoption of Resolution XI.

RESOLUTION XI

(ROBERT B. WILKINS, M.D.)

WHEREAS there will be an increasing need for the services of well-trained registered nurses in Alaska, and

WHEREAS there is at present in certain areas of the State an inadequate supply of such services, and

WHEREAS travel and other costs involved in the undertaking of a nursing training program by Alaskans in schools in other states is preventing many Alaskan students from availing themselves of this training, and

WHEREAS the Alaska Methodist University is studying the feasibility of establishing in Anchorage a four-year training program in nursing leading to an RN and a BA degree, in cooperation with hospitals in the area,

THEREFORE BE IT RESOLVED that the Alaska State Medical Association encourage and assist this or any other institution in undertaking such a program.

Dr. Langdon seconded, and the Resolution was unanimously adopted.

RESOLUTION I was then presented and moved for adoption by Dr. Rodman Wilson, and seconded by Dr. Langdon.

RESOLUTION I

(MENTAL HEALTH COMMITTEE)

WHEREAS, the Alaska State Medical Association has taken cognizance of the American Medical Association's increased interest in mental illness and mental health and its desire to participate effectively in this problem; and

WHEREAS, the Alaska State Medical Association is, in general, in favor of President Kennedy's proposals concerning mental illness and mental health, especially as regards the need for federal, state, and local governmental, as well as voluntary and private participation in planning and action;

NOW, THEREFORE, BE IT RESOLVED that the Alaska State Medical Association endorses a state mental health planning commission as set forth by the Alaska Mental Health Association; and

BE IT FURTHER RESOLVED that the Alaska State Medical Association will nominate, if asked, representatives to this commission for appointment by the Governor.

Dr. Crawford moved and Dr. Deisher seconded that Resolution I be amended by striking out the phrase "as set forth by the Alaska Mental Health Association." Dr. Ribar moved that the motion be tabled. When duly brought to a vote, 10 favored tabling and 10 opposed. President Mills broke the tie by voting in favor of tabling.

Resolution No. II was then presented.

RESOLUTION II

(MENTAL HEALTH COMMITTEE)

WHEREAS, The Alaska State Medical Association has long been in favor of a progressive mental health program for the state, not only in hospitals but also in clinics and other facilities; and

WHEREAS, The Alaska State Medical Association noted with favor the opening of the Alaska Psychiatric Institute last October as Alaska's first public mental health facility devoted to treatment of mental illness as opposed to custodial care;

NOW, THEREFORE, BE IT RESOLVED that The Alaska State Medical Association is in favor of the announced policy of the Alaska Psychiatric Institute of accepting potential treatment cases only, not accepting patients merely needing nursing care; and

BE IT FURTHER RESOLVED that The Alaska State Medical Association favors continuing contractual arrangements with Morningside Hospital, Portland, Oregon, until overall planning is carried out.

It was moved, seconded, and unanimously voted to table Resolution II.

Resolution XIV was presented and moved for adoption by Dr. Rodman Wilson. Dr. Shelton seconded it.

RESOLUTION XIV

(ROBERT WHALEY, M. D.)

WHEREAS, the citizens of Alaska have a right under government to expect those persons practicing the healing arts to be qualified to properly perform those services which they purport to perform, and further, to expect those persons practicing the healing arts to be reputable and ethical practitioners of such art, and

WHEREAS persons advertising the performance of such healing arts may be understood to have the approval of the State Government, and

WHEREAS these services are vital to the health and welfare of the public and are inherently such that the public may be unable to judge the adequacy and propriety of such services but must instead rely on its government for this function, and

WHEREAS under present law the State of Alaska is not fulfilling these functions,

THEREFORE, be it resolved, that an inclusive professional code be enacted in the State of Alaska providing for the followings

1) *The accurate definition of the various services and subdivisions of all the professional services and skills related to the treatment of physical, and mental illness and the consideration of public health problems.*
2) *The establishment of appropriate standards for the practicing of such healing arts.*
3) *The licensing and regulation of such practitioners.*
4) *The establishment of appropriate restrictions in the use of those drugs, treatments, devices and manipulations as are known to be of possible hazardous or lethal nature.*

AND, THAT an ad hoc committee of the Alaska State Medical Association be formed to outline, after consultation with other practitioners of the healing arts, such as a code, and to submit this to the Legisla-

tive Council of the Legislature of the State of Alaska on or before November 1, 1963, and

THAT appropriate funds for the execution of this program be made available and that all members be instructed to work diligently and expeditiously to its accomplishment, and

THAT this project be considered the major project of the Alaska State Medical Association for the year and the concern of every member.

After discussion, Resolution XIV was unanimously adopted.

Dr. Rodman Wilson then presented and moved for adoption Resolution VII with Dr. Deisher seconding.

RESOLUTION VII

(Committee on Adoptions—
Anchorage Medical Society)

WHEREAS the members of the Alaska State Medical Association are concerned in adoptions and recognize the necessity of laws to protect the rights and interests of the children and parents involved and of society, and

WHEREAS we are aware of past efforts to change the laws governing adoptions in the State of Alaska,

BE IT THEREFORE RESOLVED that the Alaska State Medical Association recommend the following changes in our adoption laws:

1. *That a licensed physician shall examine the child to be adopted, and attest to the medical suitability for adoption of the child.*
2. *That a waiting period of six months after placement of the child with the prospective adopting parents shall be required before final action is taken by the court on adoption.*

BE IT FURTHER RESOLVED that we are strongly opposed to any changes in law that would make it mandatory for all adoptions to be handled through a public agency.

Dr. Storrs moved to delete Part 2. After considerable discussion, Dr. R. Holmes Johnson moved and Dr. Simpson seconded a motion postponing further action until the return of the Chairman of the Committee on Adoptions, of the Anchorage Medical Society, Dr. Peter Koeniger, who was called away by an emergency. Postponement was unanimously voted.

Dr. Rodman Wilson then presented and moved for adoption Resolution XIII, seconded by Dr. Storrs.

RESOLUTION XIII

(Robert Whaley, M.D.)

WHEREAS, the health programs of insurance companies, political and trade groups, and governmental and quasi-governmental agencies have at times resulted in the restriction of their beneficiaries to a limited choice of physician to their occasional detriment, and,

WHEREAS, this restriction is contrary to the basic principle of the private practice of medicine, therefore

BE IT RESOLVED, that the Alaska State Medical Association recommend that all third party health plans be so designed as to allow their beneficiaries free choice of any reputable qualified physician.

Resolution XIII was unanimously adopted.

Dr. Rodman Wilson presented and moved for adoption Resolution IV, seconded by Dr. Storrs.

RESOLUTION IV

(Robert B. Wilkins, M.D.)

WHEREAS, it is desirable to improve the public image of the private practicing physician, ...

THEREFORE BE IT RESOLVED that the council of the Alaska State Medical Association institute an active program for the improvement of the public relations of the profession within the State, and that a reasonable sum be budgeted for this purpose during the coming year.

Resolution IV was unanimously adopted.

Dr. Rodman Wilson then presented and moved for adoption Resolution III, seconded by Dr. Shelton.

RESOLUTION III

(R. Holmes Johnson, M.D.)

WHEREAS, we believe in the free practice of medicine and,

WHEREAS, there are those who believe in compulsory health programs which would stifle the free practice of medicine and,

WHEREAS, those who so believe are actively promoting compulsory insurance programs through legislation such as King-Anderson and

WHERAS an active program in promotion of the free practice of medicine is mandatory if such practice is to survive and endure and

WHEREAS the American Medical Association has instituted such a program very effectively through its legislative council and speakers bureau and has established recommended procedure for operation of local programs in local societies through "Operation Hometown"

NOW, THEREFORE, BE IT RESOLVED that the Alaska State Medical Association institute "Operation Hometown" as soon as possible and

BE IT FURTHER RESOLVED THAT each member of the Alaska State Medical Association be encouraged to participate in this program when instituted, as actively as possible in order to make it effective.

Resolution III was unanimously adopted.

At this point, Dr. J. P. Culpepper, Vice-President of the American Medical Association, gave a short talk on the "OPERATION HOMETOWN" kit which is available through the AMA.

The meeting was recessed by Dr. Mills at 10:15 A.M.

Saturday, June 1st, 1963

The meeting was called to order at 8:30 A.M. by the new President, Dr. Ralph Carr. Resolution VII, postponed from the previous day, was again brought to the floor for discussion. Discussion centered around the amendment proposed by Dr. Storrs to delete Part 2 of the resolution. Dr. Storrs and Lundquist spoke in favor of amendment; Drs. Koeniger, Helen Whaley and Philip Moore spoke against it. When brought to a vote, the amendment was defeated.

Dr. Simpson, with Dr. Lundquist seconding, then moved to amend Resolution VII by inserting in item #3 after item #2 to read: *"That a licensed physician shall examine the prospective parents and attest to their medical suitability for caring for the adopted child."* Motion to adopt the amendment carried, and Resolution VII was unanimously adopted as amended.

On a motion by Dr. Helen Whaley, seconded by Dr. Fish, Resolution I was removed from the table for further consideration. The amendment earlier proposed by Dr. Crawford was defeated, and Resolution I was adopted as originally presented.

On a motion by Langdon, seconded by R. Holmes Johnson, Resolution II was removed from the table for further consideration. Resolution II was unanimously adopted.

Resolution VIII was then presented by Dr. Rodman Wilson.

RESOLUTION VIII

(Robert B. Wilkins, M.D.)

WHEREAS the Alaska State Medical Association has repeatedly asserted its belief in the need for the development of self-sufficiency of the native and part-native people of Alaska including their assumption of personal responsibility for their health and well being so that these people can be integrated into the population of the state on an equal basis with all others, and

WHEREAS the United States Public Health Service - Alaska Native Health Service is operated within the State for the medical care of those persons either racially or culturally identifiable as "Alaskan Natives" whether or not these people are financially capable of caring for their own needs, and

WHEREAS the administrators of the USPHS - Alaska Native Health Service has recognized the desirability of assigning fiscal responsibility to the native people for the medical care in certain instances, as indicated by their practice of making token or even larger direct charge to their patients for medical services rendered within the USPHS - ANHS facilities, thus entering into direct competition with non-federal physicians and hospitals, and

WHEREAS in the large part the existence of the USPHS - ANHS program is based on racial factors rather than need which might be met otherwise, and

WHEREAS the current events in Birmingham, Alabama, the statement of President John Kennedy and the Attorney General of the U. S., and the rulings of the U. S. Supreme Court clearly indicate that discrimination, segregation and unequal treatment or mistreatment because of differences of race can no longer be sanctioned in this nation, and

WHEREAS the problems of the Alaskan Native peoples are primarily based on socio-economic factors rather than inadequate available medical facilities,

THEREFORE BE IT RESOLVED that the ASMA urge the Federal Government to terminate its current USPHS-ANHS program for the clinical care of Alaskan Natives, and to direct its attention to the needs of these people through program of preventive medical services and welfare type assistance as well as an active program of education which will lead to the socio-economic integration of these people into the general population on a basis of complete equality.

It was moved by Dr. Deisher and seconded by Dr. Theodore Shohl to adopt Resolution VIII. In discussion following, Drs. Hale, Robert Whaley, and Fish suggested rewording of certain portions of this resolution. It was subsequently moved by Dr. Robert Whaley, seconded by Dr. Fish, that a substitute resolution as follows replace the original resolution VIII.

SUBSTITUTE RESOLUTION VIII

(Robert Whaley, M.D.)

WHEREAS, the present discrimination between white and non-white Alaskans is intensified by the health policies of the State and Federal Government, and

WHEREAS, there is recognized a large population of indigent citizens in remote areas of Alaska requiring health care,

BE IT RESOLVED that the Alaska State Medical Association recommend that the State Government enter into a cooperative program with the Federal Government through the Alaska Native Health Service so that health care would be provided to the indigent medically needy regardless of racial origin, and only to these, with program shift of financial responsibility from the Federal to the State Government, and with progressive reduction in scale of program as these beneficiaries attain self-sufficiency.

The motion carried with one dissenting vote, and the Substitute Resolution VIII was adopted.

Resolution V was then presented by Dr. Rodman Wilson.

RESOLUTION V

(Henry G. Storrs, M.D.)

WHEREAS insurance and third party coverage of medical fees is widespread and almost customary, and

WHEREAS divulging of patient-doctor confidences is involved in obtaining settlement from said third party, and

WHEREAS such divulging is taken for granted by the physician in his ordinary practice of medicine,

NOW, THEREFORE, BE IT RESOLVED that the Alaska State Medical Association go on record as indicating that the patient has given full consent to the physician when he asks for third party payment or forms completed, for said physician to divulge any or all information concerning his illness to said third party.

It was moved by Dr. Isaaks, seconded by Storrs, that this Resolution be adopted. Following discussions, a vote was taken and the Resolution failed to pass.

Resolution VI was then presented.

RESOLUTION VI

WHEREAS exposure to radiation can be dangerous to the human body, and

WHEREAS, certain persons are trained in the use of radiation and are aware of its hazards,

THEREFORE, BE IT RESOLVED that the use of X-ray by unlicensed persons (for medical purposes) shall be permitted only if directed or ordered by a licensed doctor of medicine, dentistry, or osteopathy.

It was moved by Dr. Shelton, seconded by Dr. Robert Whaley, that Resolution VI be adopted. Motion passed with one dissenting vote by Dr. Fish.

Resolution XV was then presented.

RESOLUTION XV

(Henry G. Storrs, M.D.)

WHEREAS, the Alaska State Medical Association has a health and accident policy available to its members, and

WHEREAS the premiums were negotiated and exclusions drawn on a prospective basis to give the insurance company adequate funds to cover beneficiaries immediately, and

WHEREAS this group policy has been in effect for several years,

NOW, THEREFORE, BE IT RESOLVED that the Alaska State Medical Association renegotiate this policy in view of lowering premiums and/or extending benefits.

It was moved by Dr. Ribar and duly seconded that this motion be withdrawn. Motion carried.

Dr. Kettelkamp, chairman of the Committee on Public Health, presented a written report of his committee's work. The report was duly accepted, and Dr. Carr announced that he would reappoint the committee to continue during the coming year.

It was moved by Dr. Deisher, seconded by Dr. Morgan, that honorary membership in the Alaska State Medical Association be extended to all convention speakers. The motion carried.

Dr. Crawford stated that his report before the Legislative Council on May 29th constituted the report of the Legislative Committee, of which he was Chairman. On a motion by Dr. Wilkins, seconded by Dr. Langdon, it was voted to endorse the contents of Dr. Crawford's report.

Dr. Hale reported that subsequent to his appointment by former President Dr. Benjamin McBrayer, he had continued to represent the Alaska State Medical Association on a Committee for Practical Nurses Training Program at the Anchorage Community College. He reported that a goodly number graduate out of each class enrolling, and that the program particularly helps natives to be more self-sufficient. On a motion by Dr. Theodore Shohl, seconded by Dr. Isaaks, Dr. Hale's report was approved.

On a motion by Dr. Ribar, duly seconded, it was voted that the next Convention be held in Ketchikan. President Ralph Carr announced that the dates will be May 27, 28, 29 and 30, 1964.

There being no further business, the meeting was adjourned on a motion by Dr. Lundquist.

Respectfully submitted,
Robert B. Wilkins, M.D.
Secretary-Treasurer.

WOMEN'S AUXILIARY NEWS

Compiled by

MRS. GLENN B. CRAWFORD

1963-1964 OFFICERS

President	**Mrs. Ralph Carr**
President-Elect	**Mrs. Arthur Schaible**
Vice President	**Mrs. Philip Moore**
Secretary	**Mrs. Dwight Cramer**
Treasurer	**Mrs. Winthrop Fish**
Historian	**Mrs. Charles Chenoweth**

(Committe chairmen to be announced)

PRESIDENT'S MESSAGE

Dear Friends,

Once again we are at the end of an Auxiliary year, one that has been rewarding and of great enjoyment to me. However, at this point, I think of past efforts which would have been more effective had they been applied differently and also of the many things to be done in the future. A year in office begins with confidence and as the end approaches one realizes that "the surface has only been scratched."

It has been gratifying to see so many of you truly interested in your husbands' chosen profession and cognizant of the fact that a strong, dedicated group of medical wives can be a tremendous help to physicians and their societies. Medicine itself is second in importance ot us, following the health and care of our husbands and family. Why should this not be so? We live close to it always and are affected by it in everything that we do. I know that I do not have to remind you of the battle ahead to maintain free medicine in our country. A wife who keeps interested and well-informed can truly be an asset to her husband and to medicine.

My thanks to all of you who worked so hard for your Auxiliary this year, I have never enjoyed working with a group more than I have with you. It is forever amazing to see what we can accomplish with expanding interest and dedication.

In closing, I would ask you to continue giving the greatest support to the Woman's Medical Auxiliary and to your new president, Jane Carr, and also to make every effort to acquaint yourselves with other doctors' wives in your area. You will be delighted that you made the first move toward what may be a long and valuable friendship. Thank you.

With affection,

GRACE CATES

Dear Grace,

During the past year the Alaska Medical Auxiliary has benefited from your vigor and enthusiasm. There was a definite air of purpose about the 1963 State Convention which communicated itself to all of us, and, which it is hoped, will continue to grow.

We ladies were made aware that the Auxiliary does have reason for existence, as set down in the Constitution; and, this realization has been achieved because you worked so diligently to keep in touch with National Auxiliary aims and to pass them on to us.

The increase in State membership alone, from 42 in 1961-62 to 63 in 1962-63 proves how well you succeeded.

We thank you, Madam President, for a stimulating year; no one could have worked harder, and you have more than earned your pin.

—Woman's Auxiliary to the
Alaska State Medical Association

MRS. THUSS'S ADDRESS

In her talk following the Friday luncheon, Mrs. Thuss remarked—

"I'll never see or talk to the physician's wives who are not here—to the ones we **need** to reach; but you will—so I ask you to take some part of this message to them."

Later she added—"And now may we think for a moment about those absent physician's wives. Let's call them the members of the U.P.W.

brand of the A.A." which she explained were the "Unaware Physicians Wives of the Apathetic Americans."

For all of you, present or absent at the 1963 Convention, members and non-members, we include a summary of the body of Mrs. Thuss's entertaining talk.

"Travel to state meetings has made me aware that so many physician's wives refuse to see that our lives are changing, and, that each of us must help in our husband's fight for freedom to practice good medicine. I am disturbed because these wives offer so many excuses to avoid participating in the Auxiliary and yet many accept office in other lay organizations. Working with other organizations is good, but, not at the cost of support to the medical societies and the Auxiliary.

I think each of us, when we married a physician, assumed an obligation to support medicine, the local and state associations and the American Medical Association; and, I am convinced that this obligation can be discharged best by joining with other doctors' wives to participate in this unique club. We need knowledgable, trained physicians' wives on state and national levels, not women who are content to become silent partners.

Who would you say is the most important member in the Woman's Auxiliary to the A.M.A.? Not the president or national chairmen, but each individual member! She is the one responsible for its reputation in the smallest community, and which, multiplied in each state, eventually makes our National Auxiliary a respected and influential organization.

I imagine the individual member as being one who adds quality to each day in several ways: as a volunteer, as a citizen, as a wife and as a mother. More wives will become interested in the Auxiliary as each of us believes more strongly in our work—work which begins with you and rises to state and then to national. You can't begin at the top and work down!

Leadership begins with each single individual member and can carry you to the most desirable of all offices. I couldn't wish you a higher reward than the one I enjoy this year.

Today I have paid tribute to the individual member of the Woman's Auxiliary to the A.M.A. because it is she who has molded our past—who holds the present in her hands; and, who alone can shape our future.

She has worked with loyalty and good will towards our "Air for Excellence" in 1962-63; and, as a perfect example of the National Auxiliary's most valuable member, who has given leadership and added quality to the day. I salute your president, and with her, I salute you, the members of the Woman's Auxiliary to the Alaska State Medical Association."

WHY AN AUXILIARY?

This year the answer to this question has a special meaning. Never before in the history of the auxiliary has there been a greater need for better understanding on the part of the lay public of the role of American medicine in our democratic way if life. Never before has this role been in greater danger of being subverted by the misinformed and the uninformed, by the self-seeking politician and by the disinterested voter.

Why an auxiliary? To help create a better image of American medicine; to help create favorable public sentiment—the public sentiment that Abraham Lincoln once defined as "just a lot of talk that got someplace."

Why an auxiliary? To help the medical profession in every way possible to achieve its foremost goal—the betterment of public health. An active auxiliary can help the medical profession serve the public, whether it be in the cancer screening program or the glaucoma screening program; whether it be in the homemakers' service or any other community service. In short, we need an active auixiliary to help create a healthier, happier, and safer community in which to live.

In this election year we need an auxiliary to cooperate with our various state political action committees to help elect to public office those men who realize, as we do, that American medicine, though far from being perfect, is the best in the world and that any change toward socialized medicine is a step in the wrong direction.

Why an auxiliary? To inform the uninformed on medically related subjects; to help doctors where help is needed; to mold public opinion, tactfully, wisely, and, in all cases, to the interest of good medicine, medicine unfettered by prejudice or political influence.

—MRS. MORTON ARNOLD
Eastern Regional Vice-President

Minutes of Annual Meeting of the Woman's Auxiliary to the Alaska State Medical Association

The Annual Meeting of the Auxiliary to the Alaska State Medical Society was called to order on May 31, 1963 by the State President, Mrs. Vernon Cates.

The roll was called and the presence of a quorum, required by our Constitution, was noted.

The minutes of the last meeting were approved as read. Mrs. J. Ray Langdon, Treasurer gave her report.

OLD BUSINESS

Since the ASMA had not collected the State Auxiliary dues as stated in Res. 1, passed by the ASMA in 1962, the Auxiliary treasurer had done this and we can assume that the treasurer will continue to do so having been told by the State Medical Society Treasurer that he will not do this. However, the State Treasurer had requested that the President of the Auxiliary get the consensus of the group about accepting money from the ASMA. Dr. Wilkins, State Treasurer, stated that this idea had not been presented to the State Medical Society. Therefore Dr. Wilkins was merely making a personal request and not stating the will of the Alaska State Medical Society.

Considerable discussion followed over this hypothetical situation—the problems of making money, distances involved to tie the Auxiliary together, cost of sending a delegate to the Annual National meeting, reluctance of accepting money from the ASMA, how it might be used and the need of money to maintain the organization. Mrs. St. John made a motion asking how many would accept money should it be offered. This motion passed 18-5.

The group then discussed what we would use the money for and again after much discussion Mrs. Johnson made a motion that the money be used to increase the Scholarship Fund (earmarked only for scholarship); Mrs. Phillips seconded motion. Discussion before vote—was it a policy to set aside $200 per year for the Scholarship Fund? Mrs. Haggland, past Scholarship Committee member, said that it was a policy of the Auxiliary.

Vote on the motion 14 opposed and 13 for.

Mrs. Cates suggested that in view of the close vote and since the question was hypothetical, a committee be formed to discuss the problem and meet with the State Medical Society President, Dr. Mills. Committee appointed was: Mrs. Koeniger, chairman, Mrs. Bartko, Mrs. Crawford.

NEW BUSINESS

Mrs. Jane Carr asked if anyone was going to the National Convention this coming June as she had all the literature and was unable to go herself. There was a possibility that two members of the Auxiliary might be attending.

Mrs. Francis Phillips asked our attention to the Xmas cards she had on display at the meeting. They were AMA-ERF cards and a means of earning money for AMA-ERF.

Mrs. Cates asked if the Auxiliary would like to continue the Newsletter which had been started during her term of office in Anchorage and sent to the other members throughout the state. It was moved and seconded to continue the Newsletter. Mrs. Carr asked that it continue to be sent from Anchorage this year. Mrs. Crawford asked for news contributions from everyone and that everyone keep their addresses up to date. Mrs. Cates told the group that the first three issues of the Newsletter had cost around $60.

The Proposed Budget was then voted and passed, item by item.

Mrs. Schaible proposed a vote of thanks to the Anchorage Auxiliary for organizing the State Convention.

A motion was made to adjourn the meeting; it carried and the meeting adjourned.

Respectfully submitted,
Mrs. Winthrop Fish
Secretary

TREASURER'S REPORT OF STATE CONVENTION HELD IN ANCHORAGE—MAY 1963

Bavarian Coffee (approximately 50 to 60 members and guests). Held at Margetts' residence; Mrs. Jack Sedwick, Chairman; Mrs. W. Fish and Mrs. J. Langdon took Registration fees, etc.

Alyeska Luncheon and Chair Lift Ride (31 in attendance, including 4 guests.) Transportation in private cars.

Luncheon at Anchorage-Westward on May 31— 50 in attendance, including 5 guests.

There were 42 official registrations.

Registration fees, Luncheon fees, contributions, etc.	$414.78

Respectfully submitted—Mrs. J. Ray Langdon

TREASURER'S REPORT—1962-63

RECEIPTS:	
Received by transfer of funds	$ 901.49
Dues	607.00
Convention receipts	404.78
TOTAL	$1923.27
DISBURSEMENTS:	
National Bulletin	$ 62.00
National Dues	62.00
Printing of Const. and By-Laws	60.20
Printing and mailing of newsletters	85.30
Bank service charge	1.15
Mailing expenses	1.13
Treasurer for mailing and misc. expenses	16.00
AMA-ERF Chairman	11.00
Scholarship to Jean Ruggles	200.00
Past Presidents pins	103.00
*Scholarship Fund transferred to Savings	400.00
Convention Disbursements	414.78
TOTAL	$1416.56
Balance on hand in checking account	$ 506.71

*($400.00 in Scholarship Savings Account includes 1963-64 deposit of $200.00)

Respectfully submitted Mrs. J. Ray Langdon

MEMBERSHIP COMMITTEE REPORT—1962-63

In January 1963, letters were sent out to all doctor's wives informing them of the change in dues, date dues were due, and other pertinent information.

Mrs. William Bugh, President of the Fairbanks auxiliary sent in dues of some of the Fairbanks members, the Anchorage treasurer collected state dues from the Anchorage members and members-at-large responded to letter and sent dues to state treasurer.

Members for 1962-63

Anchorage	33
Fairbanks	10
At-Large	20
TOTAL	63 State Members

(62 National members, 3 of which are associate state members.)

Respectfully submitted Mrs. J. Ray Langdon

BUDGET COMMITTEE REPORT—1962-63

Budget Committee: Mrs. Ralph Carr, President-Elect; Mrs. V. A. Cates, current President and Mrs. J. R. Langdon, current Treasurer.

This budget was prepared and submitted at annual state meeting May 31, 1963—each item was OK'd by members.

BUDGET FOR 1963-64

President's travel	$200.00
Newsletter	100.00
Printing and mailing exp.	
President	40.00
Treasurer	20.00
Legislative Chairman	16.00
AMA-ERF Chairman	12.00
Misc. Mailing Expenses	12.00
Scholarship Fund (savings)	200.00
TOTAL	$600.00

Respectfully submitted Mrs. J. Ray Langdon

SCHOLARSHIP COMMITTEE REPORT—1962-63

We are pleased to announce that Miss Jean Ruggles is the winner of our scholarship of $200.00 this year.

1. she is a registered nurse attending the University of Alaska
2. her grade point is 3.76
3. she plans to attend medical school in 1964
4. financial help is needed.

Recommendations:

1. a scholarship of $200 be presented yearly to a deserving Alaskan girl student interested in nursing or other fields related to medicine.
2. all high schools and colleges in Alaska to have scholarship information in April so that deserving girl students can present their folders for consideration to the scholarship committee.
3. the recipient of the scholarship can attend any college of her choice.

Respectfully submitted Mrs. Paul Haggland
Mahlon Shoff
Bob Johnson

AMA-ERF REPORT—1962-63

The response to the request for contributions to AMA-ERF this year, was very gratifying. Twenty-three doctor's wives, throughout the state of Alaska, gave $5.00 each. Mrs. Cathy Davis, Valdez, Alaska, received the certificate of award for the highest single contribution. Of the two organized auxiliaries Fairbanks and Anchorage, Fairbanks received the certificate of award for the highest auxiliary, or group contribution.

During the convention, approximately 2 dozen packets of AMA-ERF note paper were sold. At the dinner dance, Friday night, sixty-five dollars resulted from the sale of orchids. Orchids were flown from Hawaii, and a former florist, Pauline Caughran, of the Anchorage auxiliary, was in charge of making the corsages. Janet Drake and Jean Strauss were the busy flower girls that night, even selling some of the corsages two or three times.

The total amount raised for the year was $550.00! Congratulations, everyone, who contributed in anyway in this drive. Alaska's medical auxiliary can be proud of its part in the big part the national Woman's auxiliary to the AMA plays in supporting AMA-ERF.

—Mary Lee Phillips

COMMUNITY SERVICE REPORT

The Community Service program for this past year has consisted chiefly in the participation of the members in the Sabin Oral Vaccine program in their locale. The participation included the following areas of service:

1. Assisting in the sorting and packaging of the vaccine for the places of administration.
2. Promoting the program throughout the community by the distribution of posters and other materials.
3. Telephoning residents listed in the phone directory to encourage their participation.
4. Cooperating with the PTA in the administration of the vaccine through the schools.

Another project has been to distribute information on the acquisition of films and material pertaining to safety in the home, school and water.

The Anchorage Auxiliary purchased a circo-electric bed for their local hospital, collected clothing and supplies for the new Alaska Psychiatric Institute and continued their program of collecting drug samples and sending them to small hospitals in the state where they could be put to use.

—Corrine Beirne

MUKTUK MORSELS

A COLUMN DEVOTED TO
MEDICAL NEWS IN ALASKA

Compiled by

HELEN S. WHALEY, M.D.

GENERAL NEWS: The Sixth Annual Cardiac Clinic was held at the Alaska Native Health Hospital in Anchorage starting Monday, September 9 and continuing through Wednesday, September 11. As in previous years it was jointly sponsored by the Alaska Heart Association, the Alaska Department of Health and the United States Public Health Service and featured visiting consultants Drs. Frank Gerbode, Cardiac Surgeon; Saul Robinson, Cardiac Pediatrician; Herbert Hultgren, Cardiac Internist; and Herbert Abrams, Radiologist. Following the Clinic in Anchorage, Drs. Hultgren and Robinson traveled to Sitka where they saw referred patients from southeastern Alaska. This year Dr. Hultgren has utilized the new state ferry system, traveling to Haines aboard the M/V Matanuska with his wife and three sons. Dr. Gerbode left Anchorage trans-polar to Paris.

August 27 to 30 were the dates of the Fourteenth Alaska Science Conference, sponsored by the Alaska Division of the American Association for the Advancement of Science and held at Alaska Methodist University in Anchorage. Dr. David R. L. Duncan served as organizing section chairman for the section of Medicine and Public Health which featured technical sessions on Tuesday morning and Friday afternoon and a Tuberculosis Seminar arranged by the U.S.P.H.S. on the afternoon of Thursday, August 29.

Visiting speakers for the Tuberculosis Seminar were Gwilym R. Jones, M.D., Chief, Communicable Disease Center Services, Public Health Service, Region IX, San Francisco, California, who spoke on "Tuberculosis Today: An Overview" and George W. Comstock, M.D., Professor of Epidemiology, Johns Hopkins University, Baltimore, Maryland, who discussed the "Epidemiology of Tuberculosis." Participating in a panel discussion of Tuberculosis in Alaska were F. J. Phillips, Chief, Unit of TB Control, Alaska Department of Health; Martha R. Wilson, M.D., Chief of Medicine, Alaska Native Hospital, Anchorage; and E. W. Gentles, M.D., Medical Director, Wesleyan Hospital, Seward, Alaska.

A group of ten research specialists from the National Institute of Health spent the last two weeks of August touring Alaska to study research potentialities in the state and inform local physicians about techniques and requirements of research. Among them was Dr. Karl Reinhardt, formerly of the Arctic Health Research Center in Anchorage. The scientists met with Anchorage area physicians at the ANHS Hospital on Friday, August 23, then visited Kotzebue and other remote areas and returned to Anchorage where they met with representatives of the Anchorage Medical Society on August 29 and participated in the AAAS Conference.

September 9-11 also marks the 11th Annual Meeting of the Alaska Hospital Association to be held in Anchorage. About 40 hospital officials from throughout the state were in attendance at the meeting which featured a two day institute on personnel management conducted by W. I. Christopher, Director of Research and Personnel Services for the Catholic Hospital Association. Sister St. Hiliary of Kodiak's Griffin Memorial Hospital was program chairman and Anchorage Providence Hospital was host hospital. Dr. Levi Browning, Alaska Commissioner of Health and Welfare, was principal speaker at the annual association banquet in the Anchorage-Westward Hotel Aleutian Room September 10.

Senator Ernest Gruening (D., Alaska) was accused by the American Medical Association in the July 8 AMA News of "unfairly attempting to smear the AMA in leading off hearings by the Senate Government Operations Subcommittee on Health with a long series of charges against the organization." An editorial in the same issue entitled "The Smear Campaign" pointed to Senator Gruening's statements as the most recent incident in a smear campaign serving two purposes:—"It is designed to damage or destroy the credibility of the profession as a witness, and it enables the proponents of King-Anderson to indulge in deception and criticism while avoiding the embarrassing issues in the bill. Public opinion is the target, and accurate information is of little consequence." The editorial went on to point out that in this instance "the AMA witnesses were present at the invitation of the subcommittee to discuss the flow of drug information and the policies of the Food and Drug Administration. The AMA witnesses were not on trial, and AMA policies were not the object of the inquiry. Yet, Sen. Gruening opened the hearing with an eight-page series of charges against the AMA."

* * * * *

KETCHIKAN: The new 80 bed Ketchikan Hospital was officially dedicated on August 11. The following excerpt concerning the historical background of the hospital was printed in the official program.

This year of 1963 marks the fortieth anniversary of the old or existing Ketchikan General Hospital. It was in February 1923 that the hospital was opened by the sisters of St. Joseph of Newark having been built in 1922 by the diocese, then known as the Catholic Society of Alaska. Through the years the hospital grew and expanded to meet the needs of the community. From the Hospital financial records it is estimated that close to a million dollars has been contributed over the forty years in free service to indigent members of the community. As state and licensing requirements became more exacting the time came when the hospital became partially obsolete. Because of the large amount of free service to the community the sisters were financially unable to replace the hospital and turned to the community for help. As a result of a letter of appeal from the hospital administration to the Mayor and Council in April 1959, a hospital advisory council was formed to investigate the situation and make recommendations. Formation of various committees followed and the studies and results led up to the contract for this new hospital being awarded in July 1961.

This new hospital for the community was made possible when the people of Ketchikan approved a bond issue to provide themselves with adequate medical facilities. The City of Ketchikan enlisted the financial assistance of the U. S. Public Health Service, Alaska Native Health Service and Alaska State Department of Health and Welfare. The total cost of the building and equipment is $2,165,000. The U. S. Public Health Service contributed $912,584 from Hill-Burton funds, the Alaska State Department of Health and Welfare contributed $506,292 from state hospital bonds, Alaska Native Health Service gave a grant of $278,226 and the people of Ketchikan contributed $468,398. The local community's contribution in the form of bonds sold is payable over a period of twenty years.

The hospital is City owned and will be operated under a lease agreement by the sisters of St. Joseph of Newark. The sisters have the responsibility of maintaining the building, grounds and equipment and replacement of equipment.

Dr. Ralph C. Carr presented the major address as President of the Alaska State Medical Association.

As of September 1, Dr. Arthur N. Wilson and son Dr. James A. Wilson were joined by another son, Dr. Arthur N. Wilson, Jr., a Board Eligible Internist. The new Dr. Wilson's background includes graduation from the University of Oregon Medical School in 1958, internship at St. Vincents in Portland in 1959, psychiatry residency at the Oregon State Hospital in 1960. He was a staff physician at the latter hospital in 1961 and then returned to a two-year residency in internal medicine at the Good Samaritan Hospital in Portland. During his training in Portland, Dr. Wilson has also worked with Alaskan patients at Morningside Hospital. Dr. Arthur Jr. is married to the former Sharon Roark, an R.N. and a graduate of the University of Oregon. They have three children. (This brings to six the number of Drs. Wilson now practicing in Alaska.)

Dr. Phyllis Smith and her husband David Moray made a trip to Colorado during July to visit relatives.

Dr. E. O. Winton took a course entitled General Practice Review at the University of Colorado in Denver June 25-29th, and then took another course entitled Recent Advances in Anes-

IN MEMORIAM

Dr. Dwight L. Cramer, veteran Ketchikan physician, died suddenly in Ketchikan General Hospital Friday, September 13, as a result of paralytic ileus. It was in 1937 that Dr. Cramer settled in Ketchikan and it was the start of a long and fulfilling medical career. Just the year before he had graduated from the University of Southern California Medical School. Before going there he had been a pharmacist and had attended the University of Washington.

Dr. Cramer had given many of his years of practice to public service, being city health officer for several years and president of the Alaska Medical Society for two years. During the war years he was active in the selective service organization and was given citations by Presidents Roosevelt and Truman. For many years Dr. Cramer has headed up the local Heart Association and in addition served for two years as vice chairman of the Alaska State Heart Association. For eight years Dr. Cramer served as a member of the old Territorial Board of Health and also played a leading role in getting the Health Center for the city, spending a great deal of time locating equipment for the building with the result that it is now one of the best equipped installations of its kind in Alaska.

Dr. Cramer is survived by his widow, Ann Lou, by sons Dwight L. Jr. of Santa Barbara, California, and Jon and Ricky of Ketchikan, and by daughters, Judy Stenford and Tonia Hansen, both of Ketchikan.

Presbyterian Community Hospital

thesiology at the University of California in Los Angeles August 7, 8 and 9th.

Mr. Warren Griffin, Health Mobilization Consultant of the Public Health Service, who resides in Anchorage, visited Ketchikan on the 15th of August with a view to obtaining storage there for one of the nine portable hospitals designated for Alaska. This would have a 200 bed capacity, 30 days capability, would include cots, x-ray and surgical equipment, a pharmacy with 60 drugs, would occupy less than 1200 square feet, and would be packaged in units any one of which would go through a standard door.

* * * * *

ANCHORAGE: Organization of the staff of the Presbyterian Community Hospital is completed and includes the following officers: Dr. George E. Hale, President; Dr. Vernon A. Cates, Vice-President; Dr. William Rader, Secretary-Treasurer; and Drs. A. S. Walkowski, Peter J. Koeniger, and Howard G. Romig, Executive Committee members. The chiefs of services are Surgery, Dr. Lester Margetts; Medicine, Dr. Rodman Wilson; Pediatrics, Dr. John Tower; Obstetrics, Dr. Peter Koeniger; and EENT, Dr. Charlie Chenoweth. The following excerpt from the hospital brochure explains the history of this new 40 bed hospital which began receiving patients in June of this year:

> In the annals of hospital construction the Presbyterian Community Hospital is somewhat unique in that public funds were not solicited for its construction. In these days of Hill-Burton Funds, State Land Grants and community wide fund drives it is refreshing to see an enterprise of this type based purely on a sound business concept. The wonderful people of Anchorage provided a goodly share of the dollars needed thru their investment in 6% interest bearing debentures which will be paid off by the successful operation of the hospital.
>
> Another major source of dollars was a substantial loan made to the hospital by the Presbyterian Church; Synod of Washington-Alaska thru its agent the Presbyterian Ministeries, Inc.
>
> Though financing is most essential in starting this hospital, the real reason we are in business is the tremendous dedication on the part of numerous men and women of Anchorage. It would be most fitting to so recognize these wonderful people by listing their names here, but space does not permit. All should be aware of the great amount of work that has been done over the years by these inspired people in order to bring this dream into reality.
>
> This group truly typifies the word "Community" which appears in the hospital's name as it is composed of men and women from all walks of life, all faiths and all professions.

The Doctors' Clinic was joined in July by Dr. Marcie Jackson a General Practitioner. Several years ago Dr. Jackson also worked with the same clinic, at that time as a laboratory technician.

Dr. Rodman Wilson is off to Europe again—this time to help move his family from Switzerland where they spent the summer to Tangier where his five children will attend school this winter.

Dr. Frank Montmorency is currently attending a two month Space School in Texas.

F.A.A. physician, Dr. John Hepler and Dr. Keith Ryan, Chief of Dental Services at the Anchorage USPHS Hospital were the objects of a CAP search when Dr. Hepler's float plane sustained damage on a moose hunt. (They got their moose.)

Dr. Joseph Shelton and Dr. Don Kettelkamp were among the early sheep hunters and returned as usual, with sheep.

Dr. George Wichman and family have recently returned from a month's vacation on Martha's Vineyard off the coast of Massachusetts. On the way back to Alaska Dr. Wichman spent a week studying at Johns Hopkins.

Summer offspring of the Anchorage medical community include a daughter to Dr. and Mrs. Harvey Zartman, a son to Dr. and Mrs. Glenn Crawford, and a daughter for Drs. Richard and Chei-Mei Chao.

Visiting medical lecturers in Anchorage this summer have included Dr. Young of the National Institute of Health who spoke at the ANHS Hospital on Carcinoma of the Cervix, and Dr. Shelton

Siegel, Associate Professor of Pediatrics at UCLA, who conducted a seminar in pediatric allergy at the 5040th USAF Hospital.

An Institute on a Clinical Approach to the Problems of Pastoral Care was held at Alaska Methodist University September 9 and 10 under the sponsorship of the Western Interstate Commission of Higher Education, the Alaska State Medical Association, the Alaska Mental Health Association and the Mental Health Division of the Alaska State Department of Health and Welfare. The Institute featured Dr. Carroll Wise and Dr. Edgar Draper discussing with members of the ministerial and medical professions such subjects as Pastoral Diagnosis, the Pastor-Parishioner Relationship, the Pastor's Role in Community Mental Health, and Pastoral Care and Treatment.

Dr. Wise, Director of Student Counseling, Garrett Theological Seminary, Evanston, Illinois, is a minister with training in psychology and guidance. Dr. Draper, Assistant Professor of Psychiatry at the University of Chicago, was a divinity school graduate before attending medical school. In Anchorage 60 ministers registered for the seminar which was then repeated in Fairbanks on September 12 and 13.

On Thursday evening, September 5, Dr. Norman Q. Brill, U.S. Air Force Psychiatric Counsel, spoke on recent advances in psychiatry.

A symposium on "Problem Drinkers" and other problems of alcoholism will be held in Anchorage on 23 November. (Time and place of meeting to be announced at a later date.)

Dr. Howard Davis, Chief, Psychological Servives for the state of Minnesota, and Dr. Dan Anderson, Hazelden Foundation Rehabilitation Center for Alcoholics will be the two out of state members of the symposium staff. Several local physicians will also take part. The two principal speakers will be here from 20 thru 26 November and will be available for special group meetings.

A special meeting for physicians and ministers is being planned for the evening of 22 November 1963.

Frank Pauls, Chief of the Alaska Department of Health Laboratory leaves in September for two years of advanced training at Chapel Hill, North Carolina, where he will study for a Ph.D. in Bacteriology.

* * * * *

ARCTIC HEALTH RESEARCH: Dr. Jacob Brody and associates have been busy tracking down almost simultaneous rubella and rubeola epidemics on St. Paul Island. The isolation of the community and the susceptibility of the population have afforded an excellent opportunity to study the epidemiology of rubella. Rubeola epidemics have been present in other communities as well and may be responsible for the activation of some cases of miliary tuberculosis.

Environmental Sanitarians Lamar Hobbs and James Anderegg have both been transferred from the Anchorage area, the latter to Washington, D.C.

* * * * *

FAIRBANKS: The Governor's Conference on Rehabilitation held in Fairbanks in August was attended by Dr. Henry G. Storrs as official representative of the Alaska State Medical Association. In his resume of the conference Dr. Storrs stated that "the emphasis was on social and educational and psychological aspects of rehabilitation more than medical rehabilitation." He further stated that "it was the hope of the State Office of Vocational Rehabilitation that a similar seminar could be held in the future with the major emphasis on the medical aspects of rehabilitation and have a very strong attendance and participation by the practicing physicians in the state." The Vocational Rehabilitation Conference was also attended by Dr. Paul S. Haggland of Fairbanks and Drs. William J. Mills, Jr., J. Ray Langdon, and Holman Wherritt of Anchorage.

Dr. Joseph Ribar attended the June AMA Convention as official representative of the Alaska State Medical Association.

Dr. Donald Tatum made a trip to Kotzebue where he screened cases of heart disease for presentation at the September cardiac clinic.

The Fairbanks Medical and Surgical Clinic has been joined by a General Practitioner, Dr. Finner who comes to Alaska from Texas.

* * * * *

JUNEAU: The Juneau Clinic has recently announced the association of two more Generalists, Dr. John J. Dalton and Dr. G. Cumming Miller, who formerly resided in Whitehorse.

* * * * *

PALMER: Dr. Boyd Skille was joined Sept. 1 in practice by Dr. Walter Cunningham. Dr. Cunningham, a general practitioner, is a graduate of the University of Minnesota Medical School with internship at St. Luke's Methodist Hospital in Cedar Rapids, Iowa. He is married and has four children ranging in ages from 3 to 8.

Dr. Vincent Hume has recently been elected Chief of Staff at the Valley Presbyterian Hospital.

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ALASKA MEDICINE

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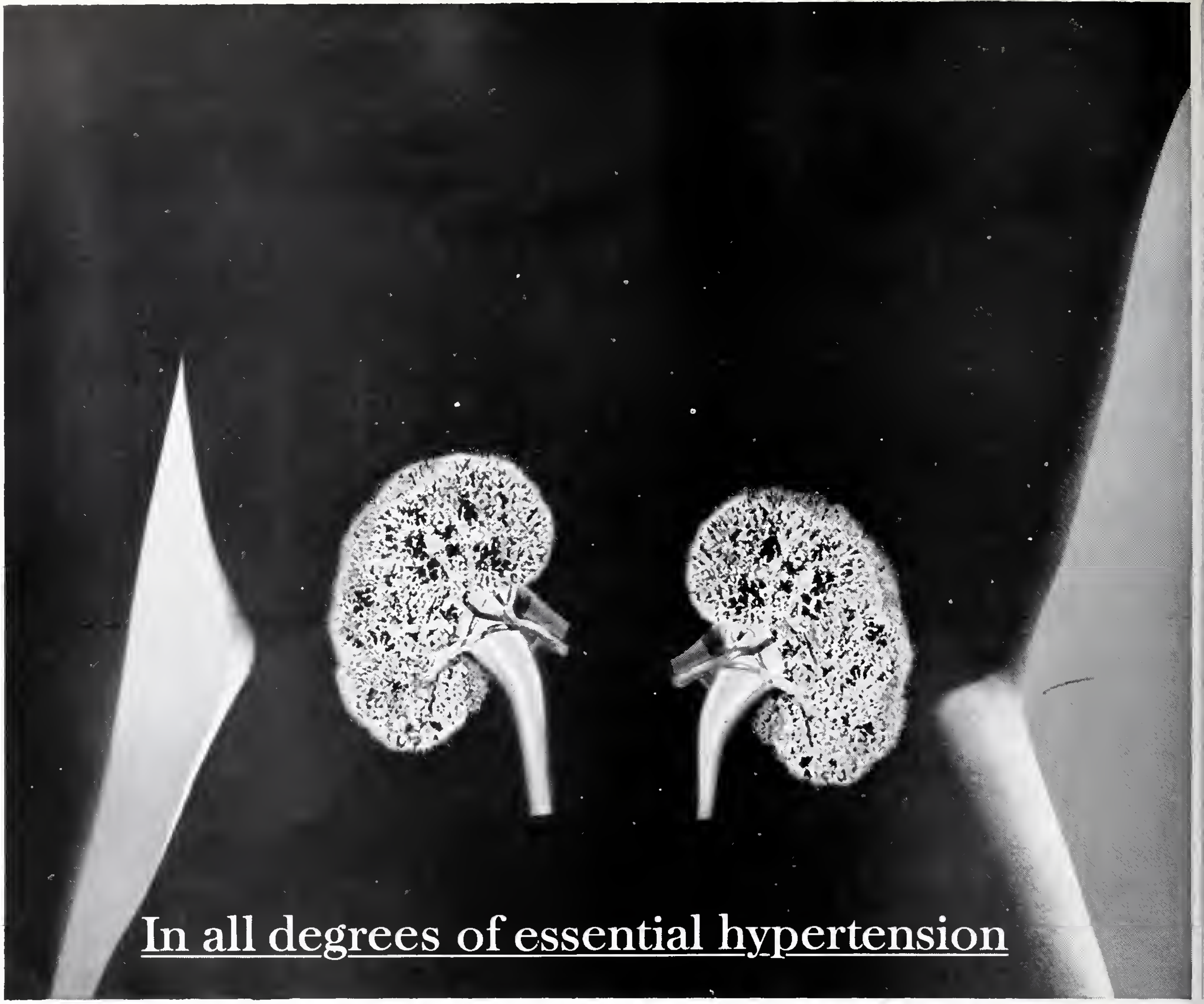
December, 1963



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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. 9:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. 63:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. 10:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. 4:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J. 23:248 (June) 1962.

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Volume V, No. 4 DECEMBER, 1963

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SINGLE TRACK VEHICLE INJURIES

DONALD B. KETTELKAMP, M.D.
WILLIAM J. MILLS, JR., M.D.

742 K Street
ANCHORAGE, ALASKA

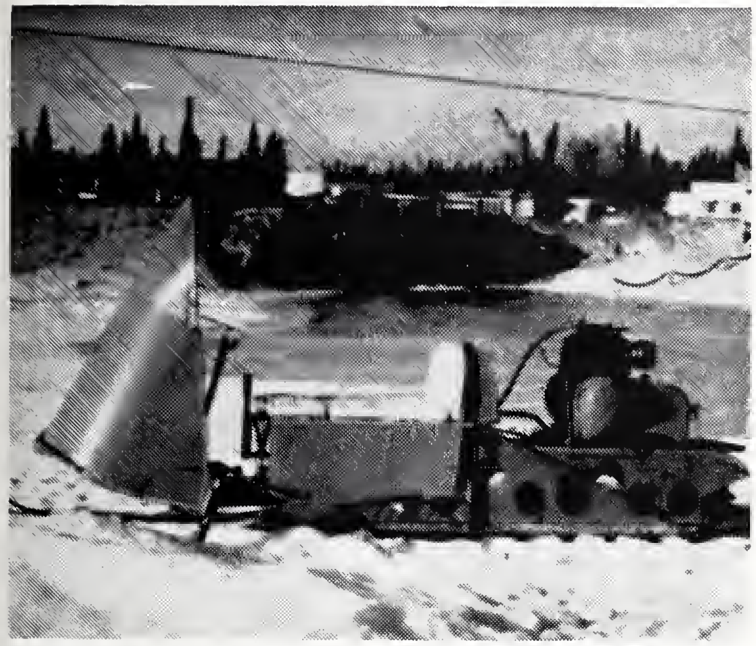


Figure 1. Single Track Vehicle.

The utilization of single track vehicles for family recreation has resulted in serious injuries. No reports of serious injuries produced by this type vehicle could be found in the medical literature. The purpose of this paper is to describe this type of vehicle, to describe the accidents and injuries sustained, and to suggest possible safety measures.

The single track vehicle, to quote one of the manufacturers, was "designed for light weight, dependable, economical transportation for persons who wish to travel quickly and efficiently where there are no roads" (Fig. 1). The Sno-Traveler, Arctic Cat, Sno-Go and Eskimotor can be classed as single track vehicles. All are equipped with skis in front. Wheels are optional on some models for tundra use. Power is provided by a gasoline engine placed behind the seat. The power is transferred to the track by belt and chain. Metal lugs on the track provide traction (Fig. 2). These vehicles are available in various sizes. They are not snow tractors or caterpillars.

These vehicles are being used by trappers, guides, homesteaders, and others whose occupations require travel in otherwise inaccessible country. An increasing number of the smaller models are being used by families for recreational purposes.

Four patients who sustained serious injuries in single track vehicle accidents have been examined. The mechanism of injury and the injuries sustained are presented in the case reports.

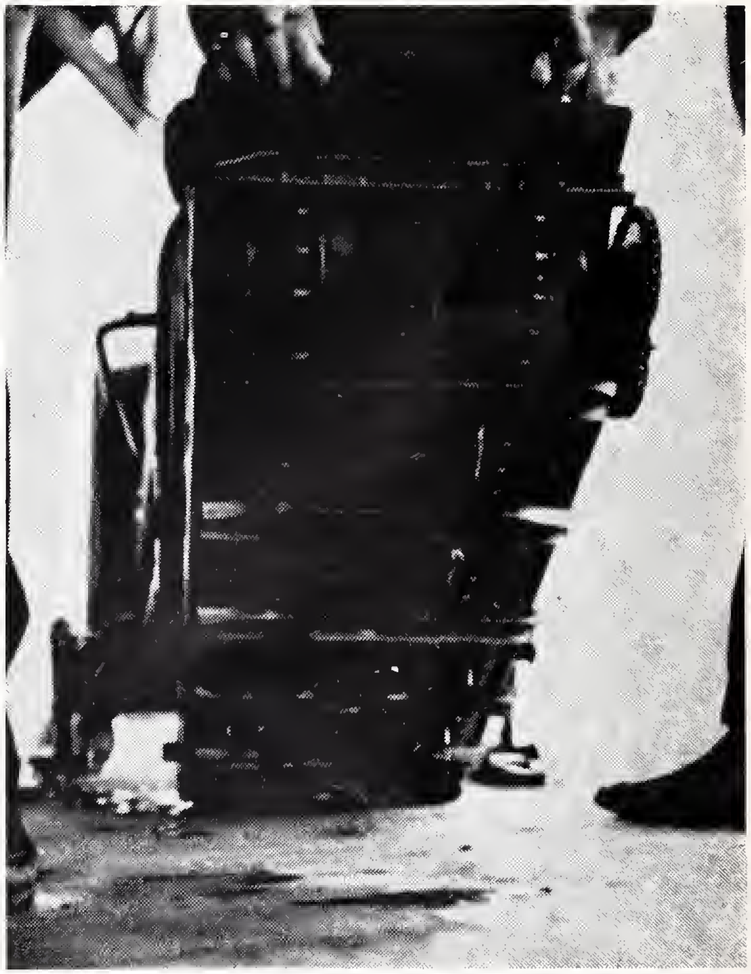


Figure 2. The track and lugs viewed from underneath.

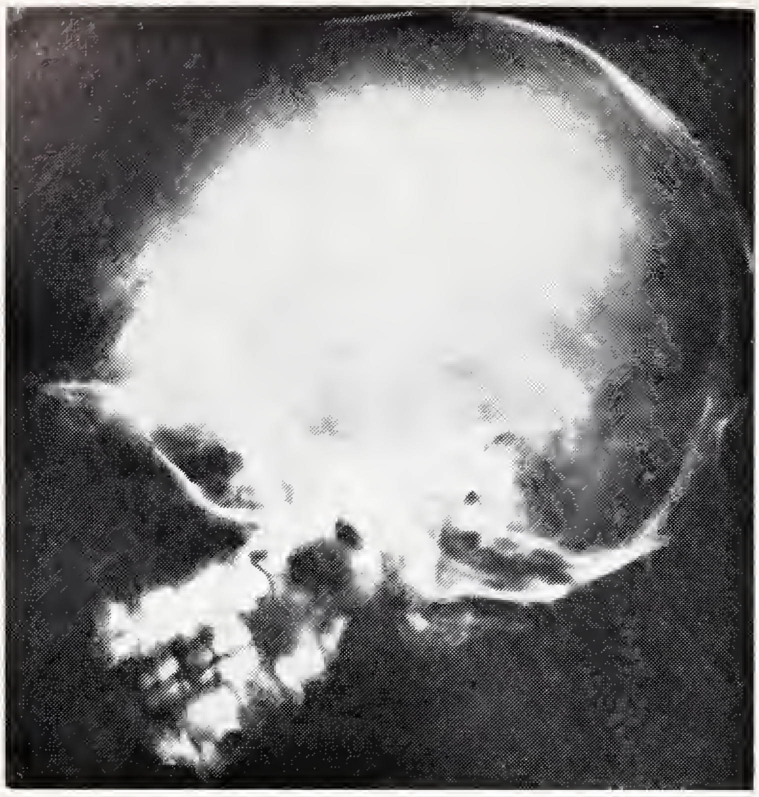


Figure 3. Skull X-ray. Note the depressed supra-orbital ridge and roof of the orbit.

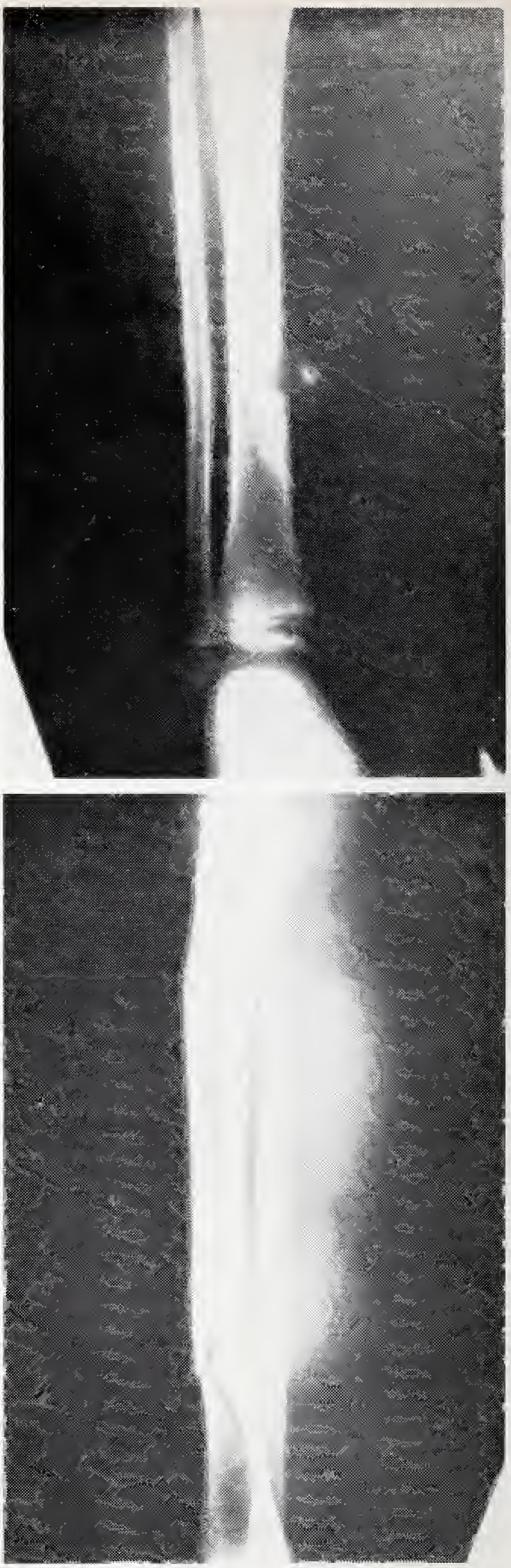
CASE REPORTS

CASE 1. T.A., age 5. Date: January 5, 1963.

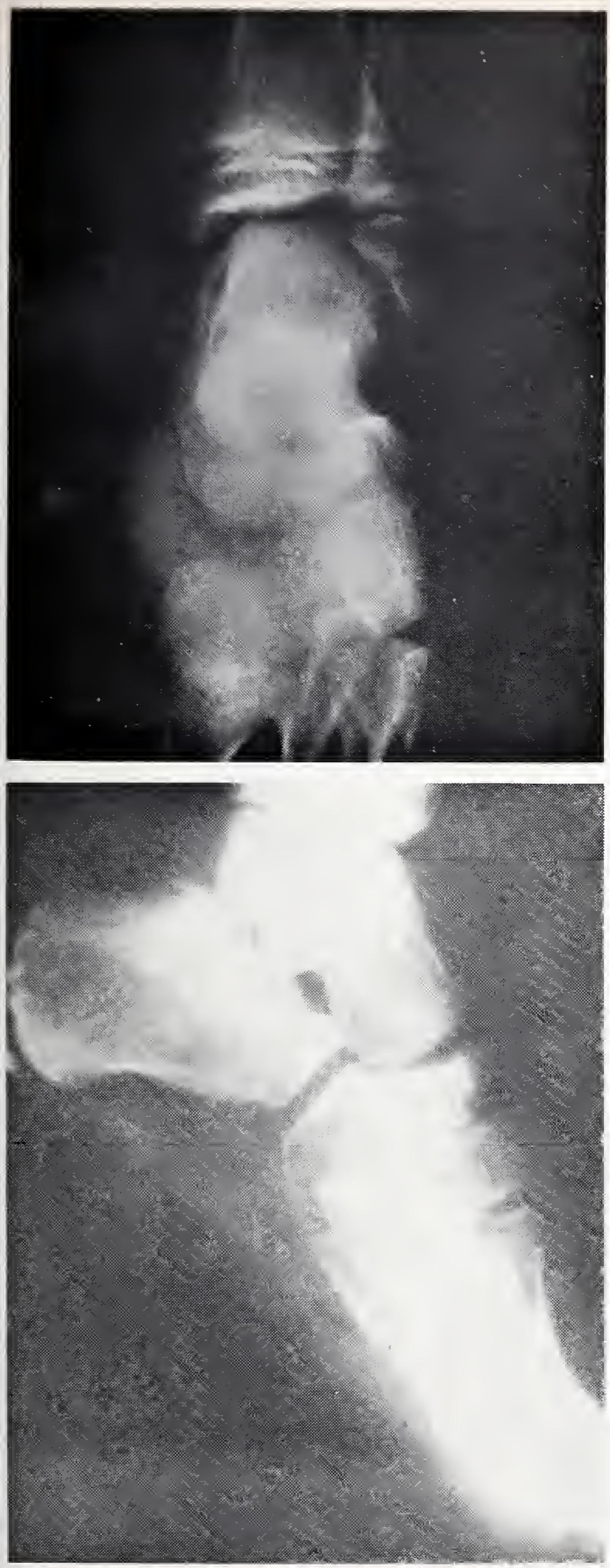
This child and his brother were being towed on a sled made of four skis. The sled became stuck when it dug into the snow. The father backed the vehicle to free the sled. The throttle stuck and the vehicle ran onto the sled. One boy jumped to safety. The other boy's left arm was caught by the track. It was carried between the track and the machine, pulling his head into the lugs. The track also ran over his right leg. The child was taken to the emergency room by his parents.

He sustained the following injuries:

1. Severe laceration left supra-orbital and frontal scalp.
2. Open skull fracture, left frontal with inferior displacement. (Fig. 3).
3. Laceration of the brain, left frontal.
4. Closed skull fracture, basilar.
5. Linear fracture right maxilla and sphenoid.
6. Open comminuted fracture of right tibia (Fig. 4 and 5).
7. Multiple contusions.



Figures 4 and 5. AP and lateral X-rays of the comminuted tibial fracture.



Figures 6 and 7. AP and lateral X-rays showing the plantar dislocation of the first metatarsal and medial cuneiform.

Debridement, wound closure and eye examination were performed under a general anesthetic by a team of physicians. Fundiscopic findings were normal, however, eye function may be compromised due to involvement of the extra-ocular muscles.

CASE 2. R.D., age 9. Date: February 2, 1963.

This boy was being towed by a single track vehicle in a remote area about fifty miles from his home. As the vehicle crossed a patch of ice the boy accelerated sliding into the track from behind. The operator felt a jolt as the boy's left foot was pulled into the machine by the track. He stopped the machine immediately without looking around. Forty-five minutes were required to extricate the boy's foot from the machine. The boy was then transported to his home where the family physician x-rayed, cleaned and bandaged the foot. The boy was then flown to a hospital where anesthetic was available.

This patient sustained the following injuries:

1. Crush injury left foot with skin changes secondary to pressure antero-medially over the navicular medial cuneiform area.
2. Traumatic amputation distal phalanx and plantar skin, second and third toes.
3. Plantar dislocation of the first metatarsal and medial cuneiform from the navicular (Fig. 6 and 7).
4. Fractures, undisplaced, of bases second and fifth metatarsal and distal fibular epiphysis.
5. Laceration left shin.

Closed reduction of the dislocation, debridement and closure of the amputation and the laceration were performed under a general anesthetic.

CASE 3. R.S., Age 11. Date: February 10, 1963.

This boy fell and the track ran over both calves. The vehicle was being driven by a fourteen year old friend. The patient was flown a hundred miles to the hospital for treatment.

His injuries were:

1. Crush injury, both calves.
2. Laceration mid right calf from posterolateral anteriorly to the tibial crest.

3. Laceration of the right anterior tibial muscle at the musculotendonous junction.
4. Laceration of the extensor digitorum longus tendons to the third, fourth and fifth toes, right.
5. Laceration, incomplete, musculotendonous surfaces peroneus longus and brevis, right.
6. Laceration of the posterior calf, left, junction middle and distal thirds.
7. Laceration of left Achilles tendon, incomplete.
8. Laceration of the left sural nerve and posterior calf vessels.

Debridement of the wounds and suture of the lacerated tendons, muscles and sural nerve and skin were carried out under general anesthesia.

CASE 4. H.J., Age 37. Date: Winter, 1961.

This man was demonstrating two vehicles in a remote village. He had started one vehicle and was starting the second. An eight year old child opened the throttle on the first machine. This vehicle struck the patient from behind throwing him onto the second vehicle. His right wrist was lacerated on the second vehicle. The first vehicle then crawled over him lacerating his knee. This patient was treated elsewhere so that the exact extent of his initial injuries are not known. The injuries evidenced by present examination were:

1. Laceration right prepatellar area.
2. Laceration ulnar dorsal aspect right wrist just distal to the ulnar styloid.
3. Laceration extensor carpi radialis, right.
4. Laceration extensor digitorum communis and extensor digiti minimi tendons to right little finger.

CONCLUSIONS

These injuries were a combination of crushing and tearing of tissue. Their treatment is predicated by the injury rather than by the etiological agent.

To use any machine safely one must first realize its potential to inflict injury. These vehicles, particularly the smaller models, appear innocuous but are not.

The proximity of children and machines not infrequently terminates in tragedy. Single track vehicles are no exception. The child, the vehicle, and the terrain all require constant surveilance.

The type of throttle mechanism presently used was at least in part related to two of the accidents. It would appear that a different throttle mechanism should be developed and that another positive method of immediately stopping the vehicle should be available.

A separate brochure provided by the manufacturers of these vehicle stressing both the advantages and hazards of family use might be of aid in decreasing the number of future accidents.

SUMMARY

Four case reports of severe injuries produced by single track vehicles have been reported and vehicles described. Safety measures have been suggested.

ACKNOWLEDGMENTS

The authors wish to thank Mr. Harold Johnson, Alaska Marine, Inc. for suggestions regarding the mechanical aspects of single track vehicles.

DISABILITY EVALUATION

GEORGE B. WICHMAN, M.D.

ANCHORAGE, ALASKA

Presented at the 18th Annual Meeting of the Alaska State Medical Association
Anchorage, Alaska, May 31, 1963

Dr. Wichman

PREFACE:

The role of therapy in the case of an injured individual is the restoration of function. If the function can be only partially restored, how can it be expressed intelligently? In the past this concerned only the individual who was unfortunate enough to have received the injury. In later years, however, organized society has assumed the responsibility by providing monitary compensation and social rehabilitation.

Logically, the physician was called upon to evaluate the extent of incapacity. But, even though the physician has been schooled in anatomy and physiology and has the therapeutic means of preventing deformity and restoring function, he finds himself handicapped in being able to appraise and evaluate the disability accurately. Society, through the industrial court, demands to know the extent of disability in terms of the percentage of loss of use of the body. Guessing casts reflection on one's integrity and qualifications. Wide differences in medical opinion breed suspicion and prejudice. If opinion is to be expressed it must be based on sound scientific reasoning the same as is used in arriving at any diagnosis. The anatomic alterations must be determined, progress prognosticated and the final healing state recognized. The extent of personal incapacity must be estimated with arithmetical preciseness.

WHAT WE MEAN BY INDUSTRIAL DISABILITY

Industrial disability is the term used to designate any permanent loss of normal function or structure known to medicine which handicaps the individual so afflicted in holding or obtaining industrial employment.

The medical evaluation of an industrial disability consists of formulating an appraisal of the degree of permanent loss in the ability of an individual to obtain or hold industrial employment.

Medical knowledge can reasonably be assumed to confer special qualifications only in regard to conditions known to medicine and in the effect of these conditions on the function of the human body. The physician finds himself handicapped in appraising the effect on the individual of such intangible factors as disappointment, shock, failure, social disapproval, loss of self-respect, and a host of other equally real, but nonmedical sources of human incompetency.

HISTORY

In the past several years methods have been applied for the evaluation of disability mostly based on the experience of single physicians who dealt with industrial practices.

Lasher, in 1942, stated that scheduled losses may be determined on a physiological basis, or an anatomical basis, or both. It was his opinion that the anatomical basis was the simplest and the most accurate. **Paul Magnuson**, in 1942, contended that the physician must not allow himself to be caught between the injured individual and the insurance carrier. He stated that an interpretation of the disability must be based on X-ray findings, on the range of motion, and on the temperament and character of the injured individual. He pointed out that most of the compensation laws require an estimation of disability based on the inability to perform any and every kind of work. This places the physician under a handicap at the start since he does not know what is involved in "any and every" kind of work.

Another doctor, **Dr. Moorehead**, pointed out the need for determining a disability on the basis of the patient's capacity to perform activities, on the state of repair of injured tissues and on the external appearance of the injured member. He gave the value of 60% to function; 20% for union and 20% for contour. He further stated that in the lower extremities, locomotion and weight bearing were important as were the ability to push, pull and grasp in the upper extremities.

Dr. Nelson Howard stated that the Laws of California required the physician to describe objectively the arc of lost motion and compare it with the normal arc. A description of other objectively measured factors is also required. The Industrial Commission in California then determines the percentage of disabiilty on the physician's objective findings.

Dr. Nichols believed that the estimation of disability is complex and at best can be the examiner's honest opinion as the physician does not necessarily have any personal experience as a laborer, switchman, mechanic, etc.

Dr. Walter Stern suggested that permanent partial disability should be valued as a percentage of permanent total disability. This evaluation could be based on fixed table ratings, modified by important variable factors.

The variable factors he mentioned consisted of age; type of occupation; the presence of pain; the will to work and other psychic factors.

Dr. McBride stated that function and ability to work are the measuring rods of the disability. Function he divided into seven distinct factors and gave each unit a distinct value in relationship to 100%. For example:

Quickness of action equals	10%
Coordination of movement	20%
Strength of effort	20%
Security and confidence	10%
Endurance and activity	20%
Safety as a workman	10%
Prestige	10%
Total	100%

The principle of applying relative values to each of these variables is ideal, but a method of objectively measuring them seems at the moment to be exteremely difficult.

The men I have just mentioned were pioneers in applying scientific principles to disability evaluation. But, it was George Rice, a Minneapolis physician, who suggested a practical method for disability evaluation which could be used by any physician with **equal results.**

Dr. Rice has recommended that the calculation of disabiilty in the extremities should be based upon values of joint motion. According to him most disabilities causing loss of function result from loss of motion which can be objectively determined. The author contended that this way the calculation can be standardized. He felt that the only responsibility of the physician is to determine the anatomical or functional loss. He suggested that it is the responsibility of the Industrial Commission to rectify the inequalities of financial remuneration, age, sex, occupation, and employability.

Rice further stated that if one of the joints (units) of a member possesses 100% of normal motion and loses 40% of this motion, it is evident that the joint is 40% disabled. The arc of retained motion is obtained and subtracted from normal motion.

He defines the term **industrial member** as part of the extremity for which a specific indemnity has been awarded in accordance with the specifications of industrial laws. Each industrial member is composed of one or more units demarcated at the joint. For example: the thumb has 2 joints, the fingers 3. He states that any disability of the joint shall constitute a percentage of disability in the industrial member which can be determined by multiplying the percentage of disability by the value of the joint as it pertains to the entire industrial member.

He also establishes the relative values of each joint to the industrial member. He calculates: Disability X value of the unit in relation to the whole industrial member.

For example: 50% value of joint X 50% disability of joint=25% disability.

In Doctor Rice's table each unit of the arm receives the following relative values:

thumb-metacarpal	50% of hand
index	14%
middle	20%
ring	13%
little	10%

In units of the finger:

the distal phalanx	50% of the finger
the middle	65%
the proximal	55%

The rating is based on the smallest industrial member.

The principles that Rice evolved have now been refined and standarized and used in the formulation of a guide for the evaluation of permanent impairment of the back and extremities which was written by the AMA Committee on Medical Rating of Physical Impairment and was published in 1958. It is the one used today.

This committee was composed of the most outstanding physicians in the industrial field. They established the following terminology which I quote:

(1) Permanent disability is **not** a purely medical condition.

(2) Permanent impairment **is** a purely medical condition and consists of any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved. The permanent impairment is a contributing factor to, but not necessarily an indication of, the extent of a patient's permanent disability.

(3) Evaluation of permanent disability is an administrative **not** medical responsibility and function.

(4) Evaluation of permanent impairment is a function which physicians alone are competent to perform. Competent evaluation is based on accurate objective measurement of function and avoidance of subjective impressions and non-medical factors. It cannot vary because of circumstances of its occurence or the geographic location of the patient at the the time. It is evidenced by loss of structural integrity, pathology or pain substantiated by clinical findings.

This particular guide of the AMA contains material on:

(1) The technique of measurement

(2) Tables of relative impairment due to restriction of movement,ankylosis, amputations, fractures and other conditions.

(3) And methods for combining and relating various impairments.

As one becomes acquainted with this material, its simplicity and uniformity of application becomes readily apparent.

It is **again** emphasized that no attempt is made by the physician to evaluate the social and economic effects of permanent impairment. It is suggested that these effects should be evaluated by the administrators in making determinations of permanent disability.

In this standard AMA guide methods of combining and relating various impairments are uniform, explained in detail and examples, and require a minimum of computation.

In general the method employed to **relate** impairments is to give the percentage relationship of the smaller parts to the next larger part in the appropriate impairment table for the smaller part. This process may be expressed in terms of impairment of the whole man.

The method generally employed to combine various impairments is based on the principle that each impairment acts, not on the whole part, but on the portion which remains after the preceding impairment has acted. When there is more than one impairment to a given part, those impairments must be **combined before** the conversion to a larger part is made. A combined values table has been provided by which any combination of impairments may be easily found.

The final impairment value is to be expressed in terms of the nearest five percent after all impairments have been computed and transposed to a common denominator.

POISONOUS PLANTS IN ALASKA

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Dr. Heller

In general, relatively few of the thousands of plants growing in the wild are used as food by man. Thus, under ordinary living conditions found in the United States today, poisonous plants are not much of a threat to man personally. They have on occasion, however, caused serious economic loss among his domesticated animals, especially in the western part of the country.

Among the 50 states, the situation in Alaska is somewhat different. A significant part of the population, chiefly Eskimos and Indians, but some homesteaders too, obtain the greater share of their subsistence from nature's bounty. And even though the rest of the State's population is more or less urbanized, much leisure time is spent by urbanites in hunting, fishing and camping. On occasion, some of these outdoor enthusiasts have literally been forced in emergencies to "live off the land." Even though plant life is, at best, a minor source of calories, under these circumstances the edible varieties constitute an important emergency food and the poisonous varieties a danger.

CICUTA—Poisonous Water Hemlock

Not too long ago it was popularly believed that there were no poisonous plants in Alaska; that if stranded in the wilderness one could safely eat any living plant. This would have been a most uncommon state of affairs if it were true. But botanists have found that Alaska, in common with many other parts of the United States and Canada, does have some poisonous plants. Among them is one of the most deadly plants on the North American Continent—Cicuta (pronounced "Cykoota")—a member of the Umbelliferae family, commonly called the carrot or parsley family.

This plant, popularly known as beaver poison among Alaska's Eskimos and Indians, and as poison water hemlock in the rest of the United States, grows in wet meadows and ditches, in shallow quiet streams and around the swampy edges of tundra lakes and ponds. Every year or two several deaths are attributed to eating this lethal plant—usually as the result of mistaking its early spring growth for one of the edible members of the same family.

Fourteen members of the parsley family grow wild in Alaska. Three of them—the stalk of the early spring growth of the coarse, stout cow parsnip **(Heracleum Lanatum Michx)**, and the young tender leaves of two somewhat smaller plants, **Angelica lucida L.** and **Ligusticum hultenii Fern.** are eaten and relished by many Eskimos and Indians.

Cicuta is easily distinguishable from these edible plants. (Note plates 1, 2, 3, and 4). Its leaves are very narrow and sharply serrated. The root structure is very characteristic and distinctive. It is bulbous in appearance with rings or ridges on the outside from which usually grow many spindle-shaped rootlets. Rootlets also grow from the bottom of this structure. When the root is split open there are very clear cut transverse sections and on the cut surfaces small globules of a very disagreeably aromatic, yellow to orange, resin-like substance usually form.

The poison principle in this plant is cicutoxin. It is found in all parts of the plant, and especially

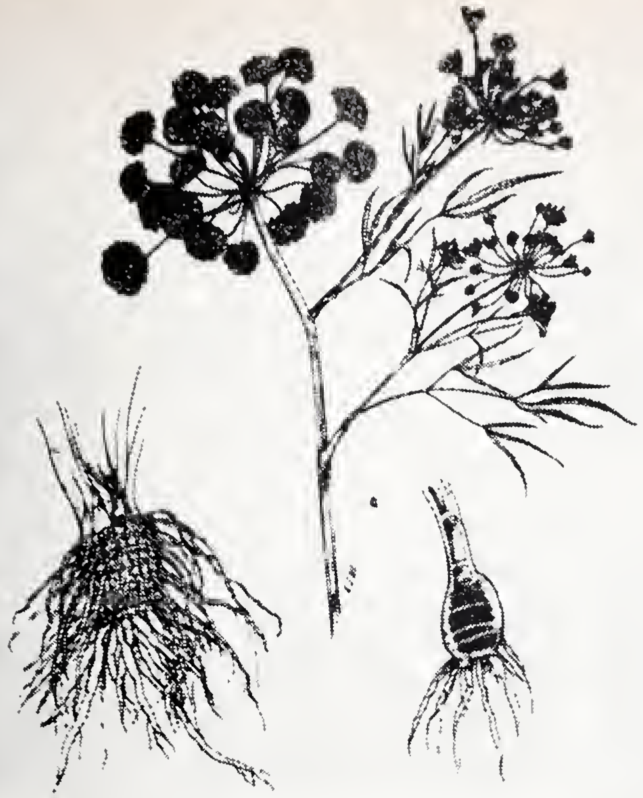


Plate 1. *Cicuta Mackenzieana.*

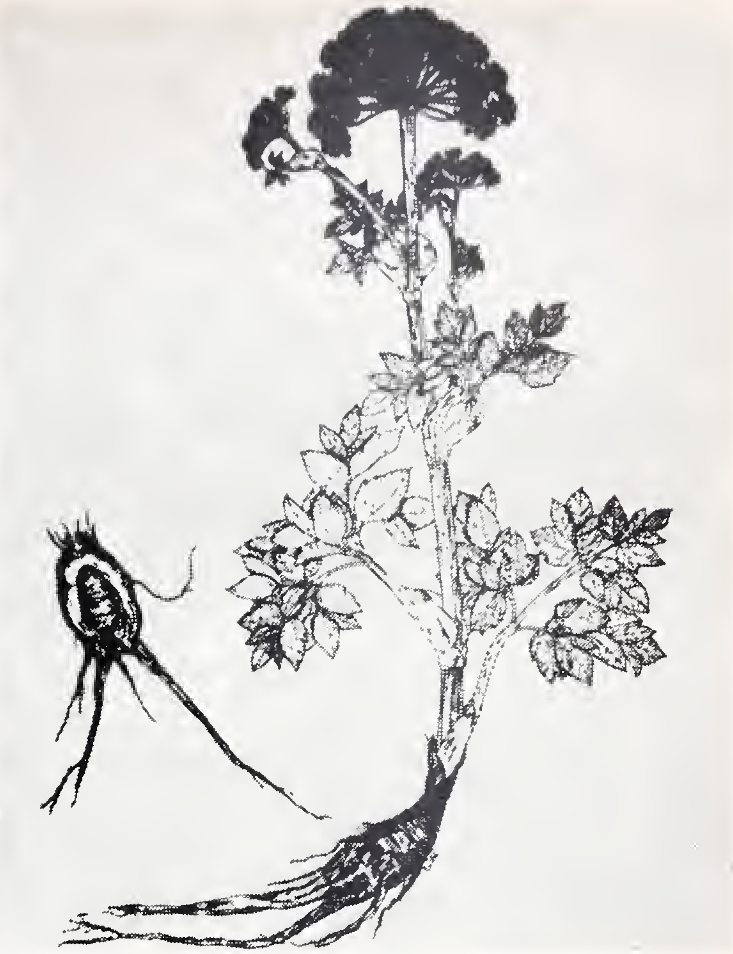


Plate 3. *Angelicum lucida.*

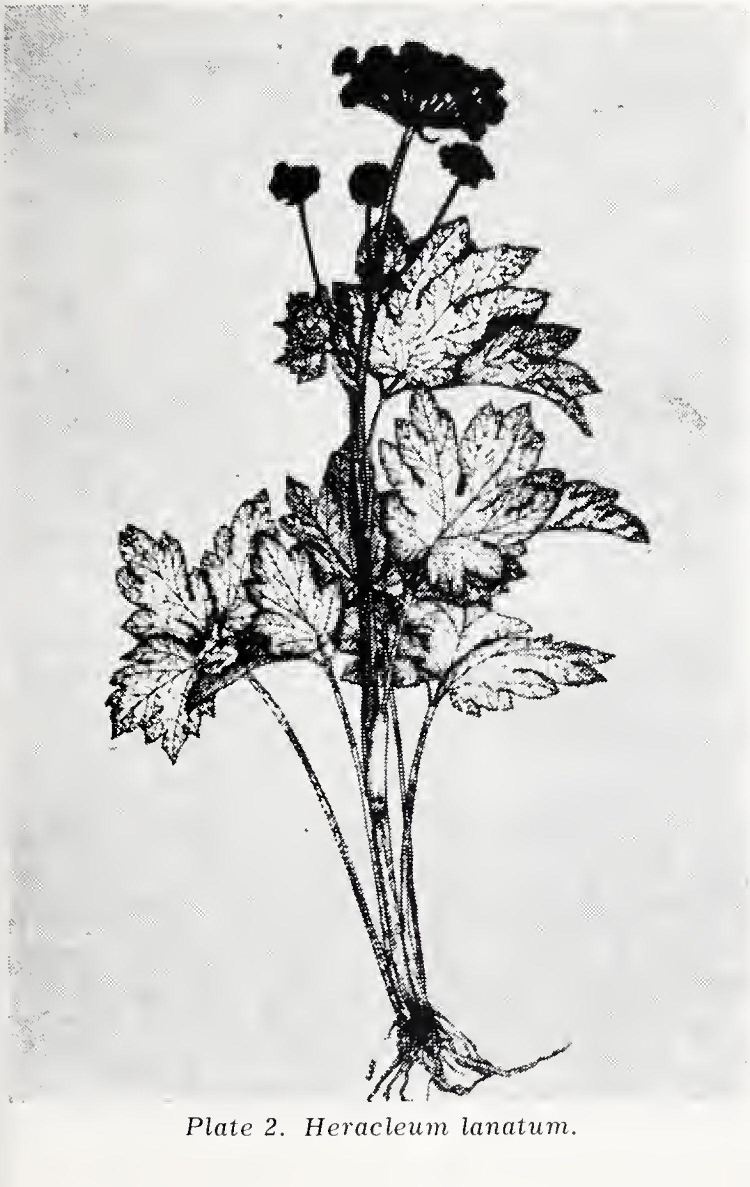


Plate 2. *Heracleum lanatum.*

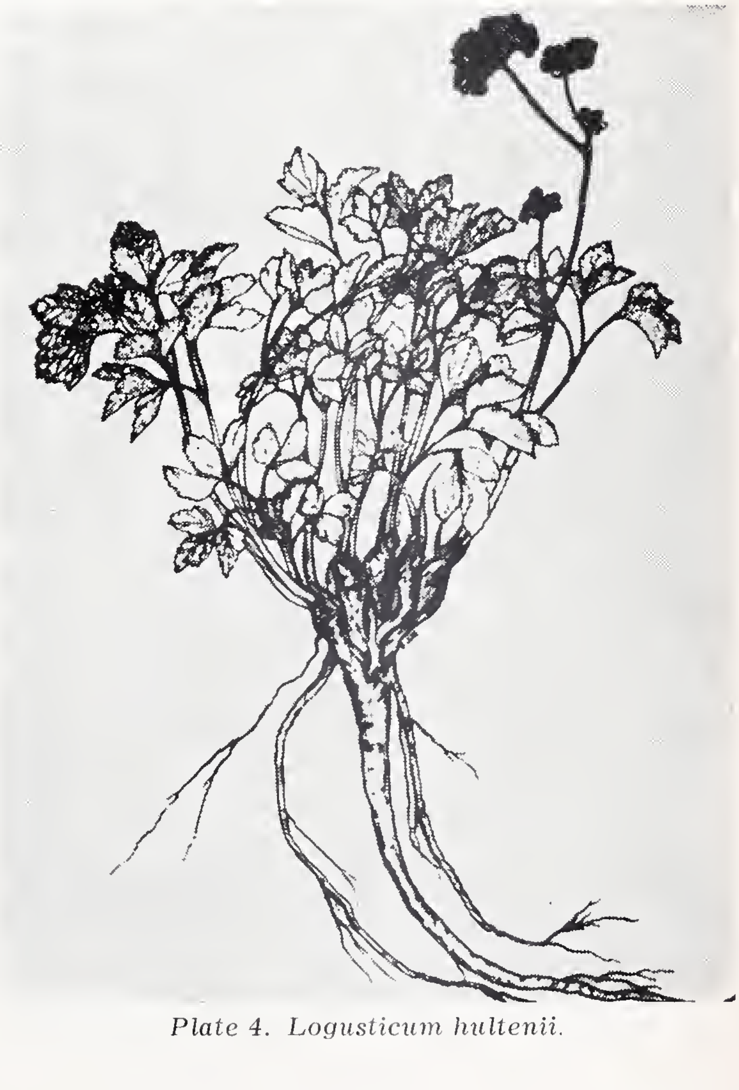


Plate 4. *Logusticum hultenii.*

in the root. Muenscher says that "a piece of the root about the size of a walnut will kill a cow." The symptoms of poisoning in man are violent vomiting, diarrhea, dilated pupils, labored breathing, sometimes frothing at the mouth, weak and rapid pulse, and violent convulsions. Death results from respiratory failure.

The poisonous or non-poisonous nature of a plant is not something known instinctively. It must be taught, with frequent reminders. Use of visual aids, such as posters and slides, particularly in **color**, is strongly recommended. In most instances after eating Cicuta, unless the stomach is emptied immediately and followed by a cathartic, death is inevitable, usually within a few hours.

Most deaths resulting from eating this plant have occurred in the Bristol Bay and Southwest tundra areas where conditions for its growth and propagation are particularly good. Fatalities occur most frequently among children age 7 to 10 who are not yet knowledgeable about tundra plant life.

Cicuta, however, is not confined to areas inhabited by Eskimos and Indians. In the Anchorage area I have found it growing at the edge of Spenard Lake, in wet ditches along the Sterling Highway near Potter, at the Girdwood Bog, in the swamps along Glenallen Highway, in the Eklutna area, in the swamp inlet to Big Lake, and in Cottonwood Creek which flows between Kings Lake and the Finger Lakes near Palmer and Wasilla. I have also found it growing around the edges of a small pond on the University of Alaska campus at College.

Two species of this plan grow in Alaska. **Cicuta mackenzieana**, which has very narrow, sharply serrated leaves, is the most widespread. It has been found to grow from the Central Pacific Coast District (Valdez, Hope, Kenai, Matanuska, Eklutna, Talkeetna and Willow Creek), north to the Central Yukon District (Circle, College, Richardson Highway), westward to the lower Yukon, the Bering Sea and Bering Straits Districts and on Kodiak Island.

Cicuta douglasii (DC) Coult. & Rose, which has slightly broader leaves, is found in Southeast Alaska from Hyder north to Skagway and Yakutat, westward throughout the Prince William Sound and Cook Inlet areas and north to the Central Yukon District (Circle Hot Springs, Tanana Hot Springs, Fairbanks).

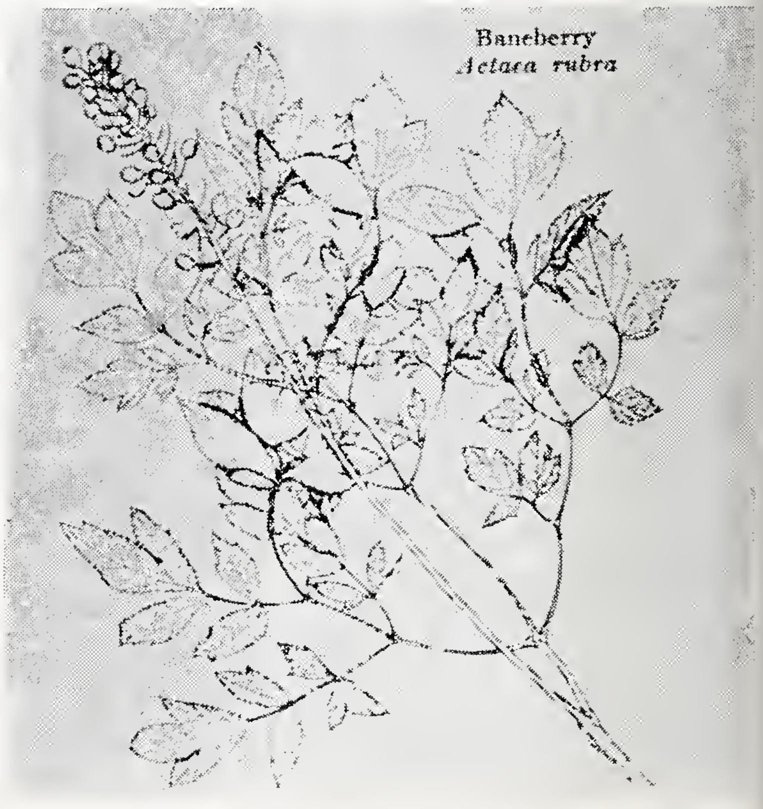
Because these two plants are so widespread and because of the popularity of camping, hunting and fishing in many of its habitat areas, every Alaskan should become thoroughly familiar with their characteristics and learn to recognize them in all stages of growth. Children, especially, should be taught to recognize the plants for they are the most frequent victims.

About three years ago the Alaska Division of Public Health conducted a campaign in Southwest Alaska under the direction of Miss Dorothy Craig, Health Educator, drawing attention to the danger of Cicuta. That year no deaths occurred among Eskimo children. This past year, however, two children died at St. Michael, indicating the need for continued education and emphasis.

Other poisonous Alaskan plants that might mistakenly be thought edible are:

BANEBERRY (Actaea rubra (Ait.) (Wild.)

This plant, 2 to 3½ feet high, grows in woods and thickets from Southeastern Alaska north to the Yukon River Districts. It is found throughout the Alaska and Kenai Peninsulas, on Kodiak Island, and in the Bristol Bay area. The fruit—berries, sometimes white, sometimes red—grow at the end of a tall stalk. As few as six berries can cause increased pulse, dizziness, burning in the stomach and collicky pains. The root stock is a violent purgative and emetic. This plant is attractive and sometimes used as a garden plant, but its cultivation is ill-advised if there are small children in the family.



LUPINE (Lupinus noatkatensis Donn. ap. Sims)

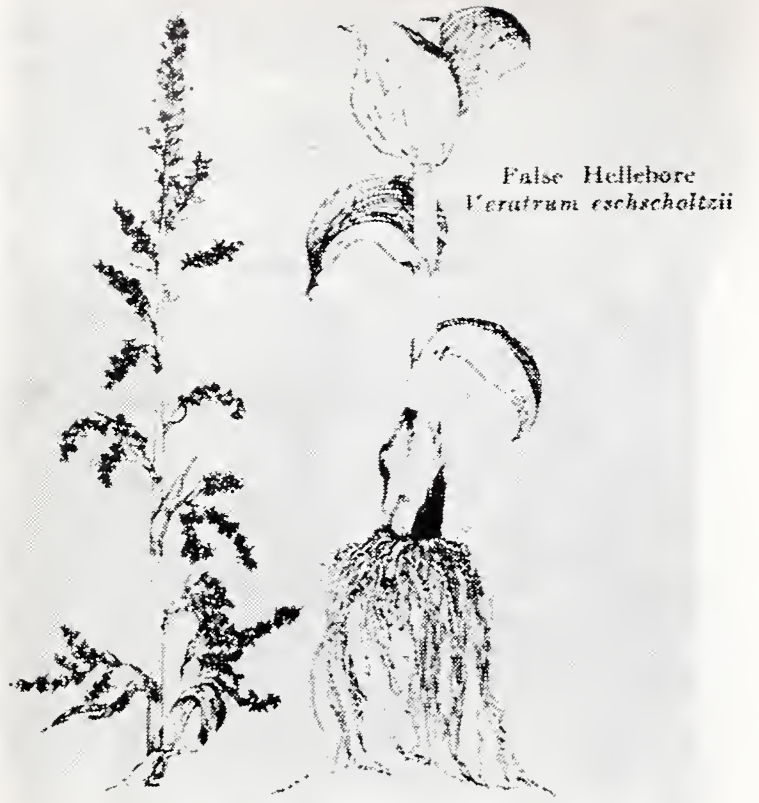
Lupine is widely distributed in Alaska. It grows on hillsides, in open fields and along roadsides throughout Southeast Alaska, north to the Alaska Range and westward throughout the Aleutians, the Pribilofs and in the lower Kuskokwim Valley.

All parts of the lupine plant are considered toxic, especially the seeds. A number of alkaloids — **lupinine, lupanine and sparteine**—have caused fatalities among livestock. However, the Aleuts have used the root of **Lupinus noatkatensis** as a food. They are collected in October; the outer skin is always removed and the inner portion eaten raw or boiled, but, according to early reports, not always without disagreeable effects, sometimes even death. Death, apparently due to severe inflammation of the stomach and intestines, was attributed to the ingestion of too much woody fiber.

ASTRAGALUS, OXYTROPIS
(Vetch or Locoweed)

A number of species of Astragalus and Oxytropis, members of the pea or bean family, grow throughout the State, from the tip of Southeastern Alaska to the Arctic. They are especially prolific in Arctic-Alpine situations but dry roadsides are also a favorite habitat. Astragalus and Oxytropis are not generally considered edible plants, however some Eskimos do use the root of **Oxytropis Nigresceus (Pall.) Fisch.** On Barter Island this food if called "Eyeahk". The root is very woody and for this reason alone should not be used except as a possible emergency food and then very cautiously.

Several species of Oxytropis and Astragalus, growing in the South 48 states have been reported toxic to livestock, causing loco poisoning. In Oxytropis, the poisonous principle is locoine, the ingestion of which causes the animal to stagger, lose muscular control and eventually die. Astragalus, on the other hand, has sometimes caused poisoning due to the large quantities of selenium and molybdemum which it is able to absorb when these minerals are present in the soil upon which it grows. Even minute amounts of these minerals in animal feed can produce such symptoms as "blind staggers" (selenium) or poor growth, brittle bones and anemia (molybdemum). The species growing in Alaska are not known to be poisonous, but the possibility exists, depending on the mineral composition of the soil upon which they grow. They should always be suspect.



VERATRUM OR FALSE HELLEBORE

Veratrum eschescholtzii A. Gray, is a tall, robust plant with broad, stem-clasping, longitudinly-veined leaves and with panicles of green flowers at the top of the stalk. It grows in wet or swampy ground in Southeast Alaska, on the Alaska and Kenai Peninsulas, in the Talkeetna Mountains, on Kodiak Island and in the Bristol Bay area. **Veratrum album L.** grows on Seward Peninsula, in the Kokrines, and on the western-most Aleutian Islands.

According to Muenscher, Veratrum contains several alkaloids—veratridine, veratrine, jervine, cevadine, veratralbine. This plant, an important ancient herbal medicine, was used to treat certain heart conditions, but its effect is apparently difficult to control. In animals the symptoms of poisoning are salivation, vomiting, purging, abdominal pain, muscular weakness, general paralysis, muscular tremors and spasms and occasionally convulsions. Death is from asphyxia.

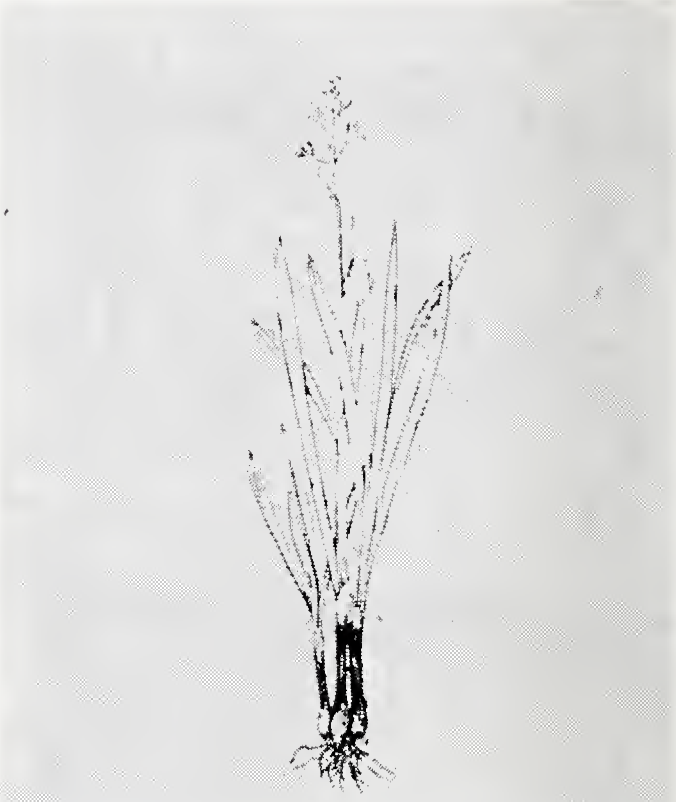
RED-BERRIED ELDER (Sambucus racemosa L.)

This plant, a shrub 3½-14 feet high, is found in woods and open places throughout Southeast Alaska and Kenai Peninsula, on Kodiak Island, in the Bristol Bay area, and on the Aleutians west to Unga and Unimak Islands. The berry has been reported as poisonous but there is no definite evidence of this. In the eastern United States children have been poisoned by chewing the bark of the elderberry specie growing there. The bark, fresh leaves, young buds, flowers and root contain a bitter alkaloid and glucoside which under certain conditions produces prussic acid. Foraging has caused fatalities among cattle and sheep. The purple berries, however, are edible and can be safely used. The red berries of our Alaskan plant have not been tested for toxicity.

DEATH CAMAS (Zygadenus elegans L.)

Several species of Zygadenus, a member of the lily family, have caused livestock fatalities in Western North America. The poisonous principle is an alkaloid, zygadenine. The seeds are especially toxic, but so also are all other parts of the plant, including the bulb.

Muenscher lists salivation, nausea, followed by vomiting, lowered temperature, staggering or complete prostration, difficult breathing, and sometimes coma as the symptoms of zygadenine poisoning and states that no satisfactory remedy has yet been found for animals poisoned by this alkaloid.



Death Camas
Zygadenus elegans

SOAPBERRY (Shepherdia canadensis L. Nutt.)

This plant, a shrub 3 to 5 feet high, is found in dry, well-drained woods from Southeast Alaska north to Wiseman in Interior Alaska. The raw berry, very bitter due to the presence of saponin, is used in the preparation of a dessert by some Southeast Alaskan Indians. Saponin sometimes causes dermatitis and possibly other poisonous reactions.

ARROW OR GOOSE GRASS
(Triglochin maritima L. and T. palustre L.)

These plants, growing on beaches and in coastal salt marshes from Southeast Alaska north and west throughout the Aleutians and north to Kotzebue, might possibly be mistaken for the edible goose tongue by the uninitiated. Both are often found in about the same habitat.

Goose or arrow grass, which contains hydrocyanic acid, has elongated linear leaves, sheathing at the base. Goose tongue, however, has very fleshy, linear, but somewhat broader leaves that are prominently ribbed. Goose tongue is a popular green food in some parts of Southeast Alaska.

WILD CALLA (Calla palustris L.)

SKUNK CABBAGE (Lysichitum americanum Hult. & St. J.)

These two members of the Arum family, growing in Alaska—the skunk cabbage in the Pacific Coastal District, and the calla in shallow water in Southwestern and Central Alaska eastward—contain a pungent, acrid substance which causes intense burning of the mucous membranes of mouth and throat, and produces gastroenteritis. Boiling, heating, or thorough drying destroys the toxic principle. I have seen deer in the Ketchikan area eat the skunk cabbage with relish, but even a minute experimental taste produced a temporary but intense burning and near paralysis of the throat.

DEVIL'S CLUB
(Echinopanax horridum (Smith) Dcne. & Planch.)

This stout shrub growing in moist coastal woods, has stems and leaves armed with sharp prickles which, when imbedded in the flesh, cause painful wounds with severe swelling. No toxic principle has yet been isolated from this plant, but the wounds caused by the prickles become easily infected.

HEATH FAMILY (Ericaceae)

Many members of the heath family contain a substance, andromedotoxin, which produces salivation, tearing, an increased flow of secretions from the nose, emesis with convulsions, and paralysis of the limbs in animals feeding on them. Several members of this family are found throughout Alaska: rhododendrons, ground azalea (**Loiseleura**), heathers (**Phyllodoce** and **Cassiope**), copper bush (**Cladothamnus**), labrador tea (**Ledum**) and bearberries (**Arctostaphylos**) in alpine situations; Menziesia in moist coastal forests; and leather leaf (**Chamadaphne**), bog rosemary (**Andromeda**), swamp laurel (**Kalmia**) and Ledum in muskegs and acid bogs; **Ledum groenlandicum** in the woods of Central Alaska; and **Gaultheria** in the woods in extreme Southeast Alaska.

Oldtimers occasionally brewed a tea from the leaves of **Ledum**, but when used in excess they found it caused catharsis and other intestinal disturbances. The purple fruit of **Gaultheria** is a highly prized edible food. Bearberries are collected and used by some North Central Indians. Neither of these berries have ever been found to be harmful in any way.

A few plants, commonly considered edible, may under certain circumstances cause irritation, distress and poisoning. For example, the stiff brittle hairs of the stinging nettle (**Urtica lyallii Wats.**) produce intense itching, but usually for a short time only. The collector of this plant should wear gloves. The irritant principle is destroyed on cooking.

The leaves of the Marsh Marigold (**Caltha paustris L.**) contain an alkaloid, jervine, and the glucoside helleborin, but both are destroyed when the plant is thoroughly cooked.

The foliage of some members of the buttercup family (**Ranunculaceae**) contain anemenol, which, if the plant is eaten raw, may cause severe intestinal inflammation. This substance is volatile and will be driven off in the steam if cooked in a pot without a lid.

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EAR PIERCING

WILLIAM WHITEHEAD, M.D.

JUNEAU, ALASKA

Dr. Whitehead

For a number of years now I have been using a very simple method to pierce ears. The reason I think this method is good is that practically every female in our city, who wishes to have her ears pierced, comes to me. The method is very simple and inexpensive. I had a lot of trouble with infection and bleeding when I was using a local and any old type of earring.

The sharp portion of an ordinary diaper safety pin is cut off with a pair of wire pliers at about one inch and the dull end flattened with a file. The sharp end can be sharpened with a file whenever needed. Only post earrings are used—no other kind can be used satisfactorily.

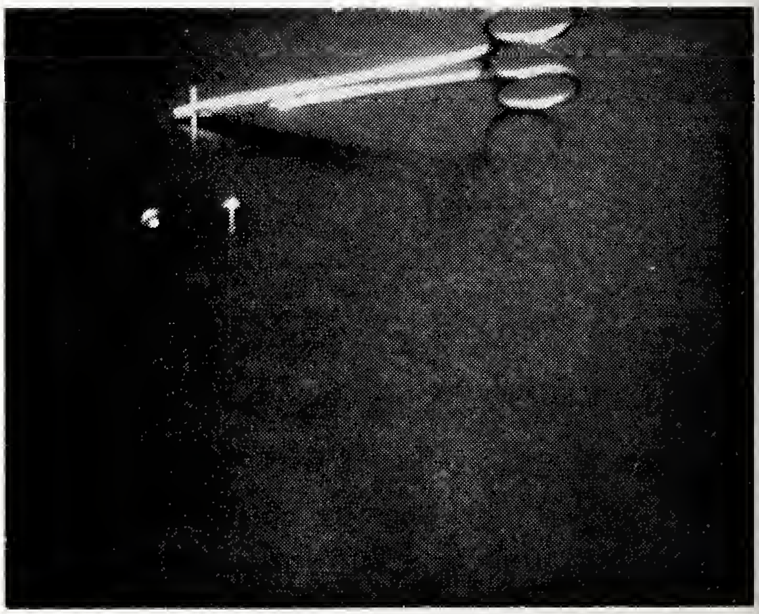
THE METHOD

The portion of cut off safety pin is grabbed with an ordinary needle holder (see picture) at the half mark after being soaked in alcohol along with the earrings. The proper site where the earring is to be placed on one ear is selected. Pushing the sharp end through the lobe, front to back, with the needle holder, down to about one-eighth of an inch, by the operator's finger. The post earring is then placed on the flattened end of the needle and pushed through the ear with the earring following the portion of safety pin. Your assistant should catch the needle in her hand. There is very little pain and no bleeding.

This is repeated on the second ear being sure to select the proper location.

Rubbing alcohol is applied to both earrings twice a day for one week. Rotate the earrings in the ears while applying alcohol. Do not remove for one week.

Try it—this is a lot of fun and satisfaction.



Dr. Whitehead's Instruments

Editorial Page . . .

WHO ARE WE AND WHERE ARE WE GOING*

We Alaskan have a unique series of challenges, opportunities, and responsibilities, for in Alaska many of the institutions long since accepted parts of life in the "south 48" are as yet not conceived or are still suffering the pangs of birth. Those of us who have sincerely chosen to cast our lots with this most underdeveloped area under the American flag have in ten short years seen and participated in the establishment of institutions of higher education, hospitals, voluntary health organizations, and a state medical journal, not to mention a state government itself in 1958 and currently units of local government. I was not among the midwives present at the birth of ALASKA MEDICINE in March of 1959 and so in order to reflect the purpose and idealism of the handful of practicing physicians who chose to produce the first issue of the journal, in lieu of a report of the feasibility of doing so, I should like to quote from an editorial written for that first issue by Dr. William O. Maddock, one of the first editors .. .

> "At first thought it might seem overly ambitious for Alaska with scarcely one hundred practicing physicians to have a state medical journal. Many states with physicians numbering in the thousands do not have a medical publication. Cogent reasons exist, however, for us to have our own journal. There is a pressing need for communication among the handful of physicians in Alaska, the largest state. The extremes of arctic and sub-arctic weather present special medical problems not encountered in the "south 48" states. The responsibilities of newly acquired statehood present organizational issues directly affecting physicians and their patients, issues which would be worthy of discussion in our own medical publication.
>
> "What should editorial policy be towards the quality and style of material to be published? It was felt that within wide limits approximately half of the material should be of organizational nature whereas the other half should be in the nature of medical reports. Should the editorial board set up a strict requirement for form of the medical reports as is done in most other American medical publications? Should we insist that all medical articles be submitted in the formal style in vogue today with **introduction** followed by **methods, results, discussion,** and then **summary** and **conclusions?** It was the opinion of the editorial board that policy in this regard should be broad . . . To sum up editorial policy, it is felt that the basic purpose of the journal should be to stimulate communication among physicians in Alaska."

My own experience with ALASKA MEDICINE began in the summer of 1961 by which time the original editorial staff were quite fatigued by the minutia attendant to editing a medical journal in addition to the rigors of their own active medical practices. Sometimes I wonder if their original enthusiasm was not drowned in a surfeit of second class mailing, news releases and exchange journals, for as soon as I came out of semi-retirement behind the kitchen stove to assume the newly created position of Managing Editor (commanding just about enough stipend to pay a part-time baby sitter) each one of them unloaded carton upon carton of this material that had been accumulating at his home or office. Furthermore, they presented me with the key to a rented, padlocked, unheated log cabin filled with a two year accumulation of exchange journals from most of the states and from countries as remote as South Africa, Finland, Rumania, and Communist China, most of them unsorted and still in their wrappers. This they hoped would someday be the nucleus of a medical library for Alaska which was then and still is unfinanced and unhoused. Gradually I have begun to understand why all these magazines had been thus hoarded, for only a doctor who has himself worked to produce a state journal can feel decided qualms upon discarding the product of another state and yet relegate journals with far more scientific stature and elaborate foremat to the trash barrel with impunity.

This has been a rather novel introduction to what Dr. Donald C. Collins in his editorial in the September AMWA Bulletin has termed the "flood

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***Presented at the American Medical Writers' Association Convention, Chicago, Illinois, October 13, 1963**

of medical trivia that inundates American medicine." I agree with him wholeheartedly that there is far too much being written about too little. In the face of the challenge, how can we state and local medical journals, considered the dregs of the barrel by the majority of physicians and advertisers alike, justify our already shakey existence. It doesn't take a long association with a state journal to be on the receiving end of comments from local specialists like "I'd rather not write anything for our state journal about the work because I'm saving it to write up some day for my specialty journal if I ever get around to it;" from a visiting convention speaker like "I'd rather not have you print my talk in your state journal because back at my teaching institution we are criticized for publishing article in too many state journals—they say we are doing it to have a long string of publications after our names;" or even from a fellow editor like "Dr. — — — really did us a favor to let us publish his article when he could have submitted it to a journal with more stature."

We of the state journals must not take ourselves too seriously or our feelings will be hurt and we will retreat disillusioned from the battle. On the other hand, we must know who we are and where we are going in order to justify our existence. Let us liken the state and local journals to amateur community baseball teams or symphony orchestras where the goal is the active participation of as many persons as possible in a form of self expression rather than passive spectator entertainment or physician education. We would then agree with that initial editorial in ALASKA MEDICINE and state that the basic purpose of a state journal should be to stimulate and increase communication among physicians within the state along medical, political, philosophical, social, creative, and even humorous lines, rather than passively to educate and indoctrinate the readers. As is the case with an amateur orchestra or ballteam, we must realize that too much criticism will stiffle the communicative spark of many a potential participant while, on the other hand, too little insistence on content and quality may discourage contributions from other sources. The criteria for judgment of material to be included in a state or local journal might then be the sincerity, aptness and effectiveness of the communication rather than the ultimate contribution to the sum total of medical knowledge. True, the medical profession is being inundated with printed material but still the actual percentage of physicians who are communicating via the written word is very small. Most physicians, once they leave the corridors of a teaching hospital or the laboratories of a research center, have no further opportunity or stimulation to communicate, yet many of them if questioned would have observations concerning the practice and art of medicine that are fully as valid and valuable as those made in a teaching institution. The state and local journals provide a medium for such communication and communication for the writer can be the link between mere knowledge of facts and understanding.

At this point we might amplify a little on the sphere of communication of the state journal and in this way suggest future purposes that a state journal might serve. Among my duties with ALASKA MEDICINE has been the handling of the subscription list and therefore I have discovered who besides the members of the state medical association and the stateside medical libraries subscribe to the journal. It is like a college catalogue to medical students and doctors wishing to settle in Alaska; it is like an alumni magazine to those who have lived in Alaska and left; it is eagerly received in foreign countries sharing our diseases and climatic problems; it is probably more thoroughly read by paramedical personnel than by physicians; and it is absolutely fascinating to the lay public. Perhaps the state journals should leave the highly technical scientific articles to the specialty journals and enter more into the almost virgin field of communication among the various branches of the healing arts working towards common goals in the same community, and even into the completely virgin field of communication between the medical profession and the lay public. Perhaps the unwillingness or inability of the medical profession to communicate with the public has contributed to the current degeneration of the physician image. Even if placing a medical journal for sale on a public newstand is below the dignity of the medical profession, an attractive, informative, and entertaining state medical journal can be mighty good waiting-room fare.

—Elizabeth A. Tower, M.D.

Roster of Physicians in Private Practice in Alaska—1963

ANCHORAGE-SPENARD

Population—54,753

Hospital Beds:
125 (Providence Hospital—Catholic)
40 (Presbyterian Community Hospital)

BARTKO, HAROLD—General Surgery
2220 E. Northern Lights Blvd.

BEIRNE, MICHAEL F.—Pathology
207 E. Northern Lights Blvd.

BILLINGS, ROBERT P.—General Practice
209 Fireweed Lane

BLANKINSHIP, GILBERT—Internal Medicine
207 E. Northern Lights Blvd.

CATES, VERNON, A.—General Practice
825 L Street

CAUGHRAN, WILLIAM R.—General Practice
Box 4-848, Spenard Medical Clinic

CHAO, CHI-MEI HWANG—Anesthesiology
1145 12th Ave.

CHENOWETH, CHARLIE E.—E.E. N.T.
Mt. McKinley Bldg.

COIN, JAMES WALTER—Radiology
Providence Hospital

CRAWFORD, GLENN B.—General Practice
203 W. Fireweed Lane

DEAL, CLYDE F.—General Practice
207 E. Northern Lights Blvd.

DRAKE, DUANE L.—Radiology
207 E. Northern Lights Blvd.

FISH, WINTHROP—Internal Medicine
501 L Street

FITZPATRICK, JAMES J.—Internal Medicine
718 K Street

FRITZ, MILO H.—E.E.N.T.
1027 Fourth Ave.

HALE, GEORGE E.—General Surgery
501 L Street

HARRELL, R. E.—General Practice
520 E. 14th Ave.

HEPPLER, LAWRENCE—FAA Contract Physician
c/o FAA, Box 440

HILLMAN, FREDERICK J.—General Surgery
207 E. Northern Lights Blvd.

HOMAY, ALAN—General Practice
207 E. Northern Lights Blvd.

IVY, WILLIAM H.—Obstetrics & Gynecology
825 L Street

JACKSON, MARCELL—General Practice
825 L Street

JOHNSON, CALVIN T.—General Practice
1104 G Street

JONES, WARREN—General Practice
207 E. Northern Lights Blvd.

KETTELKAMP, DONALD B.—
Orthopedic Surgery, 742 K Street

KIESTER, THOMAS E.—Orthopedic Surgery
207 E. Northern Lights Blvd.

KOENIGER, PETER J.—Obstetrics & Gynecology
825 L Street

KRAFT, EDWIN C.—General Surgery
718 K Street

LANGDON, J. RAY—Psychiatry
207 E. Northern Lights Blvd.

LANGSTON, DON VAL—Pediatrics
207 E. Northern Lights Blvd.

LEONG, RUDY H.—General Practice
207 E. Northern Lights Blvd.

MADDOCK, WILLIAM O.—Internal Medicine
825 L Street

MARGETTS, LESTER H.—General Surgery
825 L Street

MARTIN, ASA L.—General Practice
718 K Street

MATTHEWS, WENDELL C.—
Contract Physician, c/o FAA, Box 440

MEAD, PERRY A.—Neurosurgery
825 L Street

MILLS, WILLIAM J. JR.—Orthopedic Surgery
742 K Street

MONTMORENCY, FRANK A.—Urology
207 E. Northern Lights Blvd.

MORGAN, ROYCE—General Practice
207 E. Northern Lights Blvd.

OGDEN, GLEN—Radiology
Presbyterian Community Hospital

O'MALLEY, JAMES E.—General Practice
529 I Street

ORMOND, LOUISE—Internal Medicine
207 E. Northern Lights Blvd.

PENNINGTON, JOHN A.—Anesthesiology
2101 Turnagain Parkway

PHILLIPS, FRANCIS L.—Chest Diseases
2220 E. Northern Lights Blvd.

RABOURN, WILLIAM O.—General Practice
Box 1146, Spenard

RADER, WILLIAM—Psychiatry
305 Fifth Ave.

RENN, A. CLAIRE—Obstetrics & Gynecology
825 L Street

ROMIG, HOWARD G.—Gynecology
718 K Street

ST. JOHN, CHARLES F.—General Practice
207 E. Northern Lights Blvd.

SEDWICK, JACK D.—General Surgery
718 K Street

SHELTON, JOSEPH H.—Ophthalmology
825 L Street

SHOFF, MAHLON J.—E.E.N.T.
825 L Street

SHOHL, ROSALIE—Anesthesiology
207 E. Northern Lights Blvd.

SHOHL, THEODORE—General Surgery
207 E. Northern Lights Blvd.

STARR, MERRITT P.—Internal Medicine
825 L Street

STRAUSS, FREDERICK—Pathology
Providence Hospital

SYDNAM, NANCY E.—General Practice
140 E. Fifth Ave.

TOWER, ELIZABETH—
General Practice & Adolescence, 718 K Street

TOWER, JOHN C.—Pediatrics
825 L Street

WALKOWSKI, A. S.—General Practice
429 Fourth Ave.
WHALEY, HELEN S.—Pediatrics
825 L Street
WHALEY, ROBERT D.—Internal Medicine
825 L Street
WICHMAN, GEORGE B.—Orthopedic Surgery
718 K Street
WILKINS, ROBERT B.—Internal Medicine
718 K Street
WILSON, RODMAN—Internal Mediicne
207 E. Northern Lights Blvd.
WRIGHT, VIRGINIA—Psychiatry
529 I Street
ZARTMAN, HARVEY F.—Pediatrics
825 L Street

FAIRBANKS

Population—13,311
Hospital Beds—70 (St. Joseph's Hospital-Catholic)
BUGH, C. WILLIAM—General Practice
1255 Airport Way
CLARK, GEORGE—Anesthesiology
Box 167, College
DEELY, NICHOLAS—Pediatrics
Box 1330
EVANS, RAYMOND D.—General Practice
Box 1330
FAULKNER, ROBERT F.—Ophthalmology
Box 1330
FENNER, JOHN LEWIS—General Practice
Box 1330
HAGGLAND, PAUL L.—Orthopedic Surgery
Box 1330
HEAVRIN, LAWRENCE—General Practice
1007 Noble Street
JOHNSON, JOSEPH K.—General Surgery
Box 1330
LEIH, GEORGE G. T.—General Practice
1007 Noble Street
LUNDQUIST, JAMES A.—General Practice
1007 Noble Street
MARROW, CHARLES T.—Internal Medicine
Box 1330
MEYER, EDWARD D.—Internal Medicine
Box 1330
RIBAR, JOSEPH H.—General Practice
Box 1330
SCHAIBLE, ARTHUR J.—General Surgery
Box 1330
STORRS, HENRY G.—General Surgery
Box 993
TATUM, DONALD E.—Internal Medicine
1007 Noble Street
WESTON, JOHN I.—General Practice
411 Fourth Avenue

JUNEAU-DOUGLAS

Population—7,839
Hospital Beds—79 (St. Ann's Hospital-Catholic)
AKIYAMA, HENRY I.—Internal Medicine
188 S. Franklin
DALTON, JOHN A.—General Practice
188 S. Franklin
GIBSON, JACK W.—Pediatrics
188 S. Franklin
MILLER, E. CUMMINGS—General Practice
188 S. Franklin
RAY, E. STANLEY—General Practice
Box 2627
RAY, HOMER F. JR.—Psychiatry
303 Coleman Street
REIDERER, JOSEPH—General Practice
I.O.O.F. Bldg.
RUDE, JOSEPH O.—General Practice
I.O.O.F. Bldg.
SMALLEY, ROBERT R.—General Surgery
188 S. Franklin
WHITEHEAD. WILLIAM M.—General Practice
188 S. Franklin
WILDE, HENRY—Internal Medicine
188 S. Franklin

KETCHIKAN

Population—6,483
Hospital Beds—80 (Ketchikan General Hospital)
CARR, RALPH W.—General Practice
Box 359
SALAZAR, LOUIS—General Practice
Box 359
SMITH, PHYLLIS E.—General Practice
Box 86
WILSON, A. N.—General Practice
Box 1989
WILSON, JAMES A.—General Surgery
Box 1989
WILSON, A. N. JR.—Internal Medicine
Box 1989
WINTON, ERVIN O.—General Practice
2433 First Avenue

SITKA

Population—3,237
Hospital Beds—23 (Sitka Community Hospital)
MOORE, PHILIP H.—Orthopedic Surgery
Box 810
MOORE, TILLMAN JR.—General Surgery
Box 1000
SHULER, ROBERT H.—Internal Medicine
Box 438
SPENCER, EDWARD D.—General Practice
Box 1048

KODIAK

Population—2,628
Hospital Beds—18 (Griffin Memorial-Catholic)
JOHNSON, A. HOLMES—Semi-Retired
Box 766
JOHNSON, R. HOLMES—General Practice
Box 766
KEERS, J. BRUCE—General Practice
Box 766

NOME

Population—2,316
Hospital Beds—29
(Maynard-McDougall Memorial Hospital-Methodist)
FENSTERMACHER, ROBERT E.—Gen. Practice
Box 550
SHADLER, JOHN A.—General Surgery

PALMER-WASILLA
Population—1,852
Hospital Beds—25 (Valley Presbyterian)
BAILEY, CLARENCE C.—General Practice
Box J
CUNNINGHAM, WALTER—General Practice
HUME, VINCENT—General Practice
Box 1833
SKILLE, BOYD—General Practice

SEWARD
Population—1,891
Hospital Beds—30 (Seward General Hospital)
DEISHER, JOSEPH B.—General Practice
Box 247
GENTLES, ERNEST W.—General Practice
Box 185

PETERSBURG
Population—1,502
Hospital Beds—21 (Petersburg General Hospital)
COON, DUANE A.—General Practice
Box 1066
SMITH, RUSSELL C.—General Practice
Box 1054

BETHEL
Population—1,258 mainly native
Hospital Beds—50 (U.S.P.H.S.)
SCHIRMER, HARRIET JACKSON— Gen. Practice
Box 286

HOMER
Population—1,247
Hospital Beds—3 (Homer Hospital & Health Ctr.)
FENGER, JOHN B.—General Practice
Box 202

CORDOVA
Population—1,128
Hospital Beds—22 (Cordova Cmty. Hospital)
ARNOLD, PATRICIA—General Practice
Box 218
CHAPMAN, W. JOHN—General Practice
Box 218

CHUGIAK, BIRCHWOOD, EAGLE RIVER
Population—801
No hospital facilities
SIMPSON, MARSHALL A.—General Practice
Box 373, Eagle River

BIG DELTA
No population listed
No hospital facilities
ADAMS, FELIX M.—General Practice

KENAI
Population—779
No hospital facilities
BARR, ALLEN W.—General Practice

SOLDOTNA-STERLING
Population—492
No hospital facilities
GAEDE, ELMER E.—General Practice
Box 345, Soldotna
ISAAK, PAUL G.—General Practice
Box 345, Soldotna

DILLINGHAM-NAKNEK
Population—673
Hospital Beds—42 (U.S.P.H.S.)
LIBBY, JOHN E.—General Practice

SKAGWAY
Population—659
Hospital Beds—8
(White Pass and Yukon Railway Hospital)
SAMMAN, H. DAVID—General Practice
Box 537

VALDEZ
Population—555
Hospital Beds—16 (Valdez Hospital)
DAVIS, CLARENCE—General Practice
Box 265

GLENALLEN AREA
Population—436
Hospital Beds—3
(Faith Hospital-Central Alaska Mission)
PINNEO, JAMES—General Practice
SCHNEIDER, CHESTER I.—General Practice

HAINES
Population—392
No hospital facilities
JONES, STANLEY—General Practice

SAND POINT
Population—254
No hospital facilities
SANDBERG, CARL E.—General Practice
Box 201

Dear Doctor—Your wife is needed! Please take this form home to her.

Application for Membership in the Women's Auxiliary to the Alaska State Medical Association

Name: ....

Address: ....

$10.00 (Ten Dollars) Annual Dues Enclosed.

Please complete and remit to:
Mrs. Winthrop Fish, 1213 Bannister Road, Anchorage, Alaska

WOMEN'S AUXILIARY NEWS

Compiled by

MRS. GLENN B. CRAWFORD

PRESIDENT'S MESSAGE

Dear Members,

Greetings to all of you! Already I am looking forward to seeing you again next May 27, 28, and 29 when we meet here in Ketchikan. May we each have a successful year to report.

In early October I spent three days in Chicago attending the annual conference for State Presidents and Presidents-Elect. It was an exciting experience, one that I wish every one of you could have. **Serve and Communicate**, one of the national president's SAC programs, was the theme of these meetings. Do please read the article by Mrs. Stoltz in the May 1963 issue of the **Bulletin.**

Our national officers and committee women were there to give as much help and advice as possible, and a number of men from the American Medical Association staff gave us current information about AMA activities and answered questions presented to them. I only wish there was some way to transmit the ideas and information to you with the enthusiasm and freshness intact!

Most enjoyable, needless to say, was the opportunity of meeting so many women from the whole country all with the same aims of service that we have; all to a greater or lesser extent with the same problems; and all of them delightful friends to have. I was most fortunate to share the suite of our Western Regional Vice President, Mrs. G. Prentiss Lee, a stimulating person whom I hope you will meet some day.

With communication in mind, let me remind you that it is now possible to drive to Ketchikan via the ferry system, and in the New Year, I hope to be able to give you the exact ferry schedule. So start planning now to attend the State Convention in May!

The British Columbia division of the Canadian Medical Association will be holding its own convention aboard a chartered cruise ship and will be in Ketchikan at the time of our meetings, and we anticipate many guests joining some of our sessions.

It will be a pleasure meeting you again. My good wishes for a merry holiday season.

Sincerely,

L. JANE CARR

Mrs. Winthrop Fish has been responsible for collecting and mailing an impressive amount of drug samples not needed in local doctors' offices. These have been sent directly to Seldovia, Glennallen and Bethel, Alaska; and forwarded through the Direct Relief Foundation, Santa Barbara, California, to refugees in the Philippines, Hong Kong, Brazil, Mexico, and other needy areas.

The Anchorage Auxiliary is enthusiastic about this project, but the cost of mailing these drugs may prove too much of a strain on the treasury although the Foundation will pay half of the shipping charges. The following excerpt from a letter received by Mrs. Fish may interest our readers:

> "It would be a great assistance to us (Direct Relief) if you could approach the many doctors in Anchorage and other cities in Alaska who up to now have not had an opportunity of participating in your drug collection program. Direct Relief needs an increase in volume of drugs to be able to fulfill the most urgent requests from overseas. Of course, we realize that shipping charges present a problem, and, for this reason, we offer to pay half of them whenever you can dispatch a shipment.
>
> Please give my best to all your members, and I hope that one day we shall have the pleasure of seeing you or others in your group and showing you our medical relief center in operation."

Sincerely,

Mrs. Ilse de Mott.

ANCHORAGE AUXILIARY ACTIVITIES

Convention plans held priority for the Anchorage medical wives last spring, after which everyone relaxed, feeling that the convention had been most successful.

The luncheon meeting in September was held at the **Driftwood**, with a good number in attendance. Membership was stressed and dues were received. Ideas for programs and suggested projects for the coming year were discussed. Two of the ideas which were subsequently carried out were novel and interesting as well as remunerative and rate describing.

The cocktail buffet, held November 2 at the home of Dr. and Mrs. Glenn Crawford for members of the local medical society, was one of the highlights of the season. As guests entered the courtyard where bats were flying around, the atmosphere took on a mystical Halloween air. In the hallway they were greeted by a real skeleton —seated, holding his skull in his lap. To obtain supper and drink and play the games which were the order of the evening, it was necessary to buy "money". Supper cost $200.00 a plate! Prizes for the best costumes went to a sleek cat couple, Castro, a Frankenstein monster, and a colonial dame. The evening proved so entertaining that a repeat performance has been requested.

In place of the regular meeting on November 14, a dessert was given at the home of Mrs. Grace Cates, the Anchorage Auxiliary AMAERF Chairman. Each member brought one or more guests and paid one dollar for dessert and coffee. Throughout the house, members had arranged lovely table settings, holiday door wreaths, and decorations such as a sugar plum tree, angel tree, a Dutch shoe filled with nuts, wooden doll cones, a pink and silver sprayed centerpiece, and a large basket filled with evergreens, pine cones and gold balls. The best table setting and arrangement were awarded prizes, and some of the decorations were for sale. Proceeds went to AMAERF.

All those who participated in these events are to be commended! Detailed planning and hard work went into them, but they were well worth it. Hidden talents of several members were revealed and new interest and fun in working together was discovered.

It has not been definitely outlined nor yet accomplished, but when the year ends we shall have given generously to medical schools and students through AMAERF. A local community cause will also have been helped with a financial contribution and by personal service.

MARY LEE PHILLIPS, President.

REPORTER'S NOTE:

We regret the absence of news from around the State but hope that the New Year will produce a surplus. For this reason also, the Auxiliary Newsletter is in abeyance. So, we look for your letters in 1964!

ALASKA MEDICINE

THE FIRST THREE YEARS

1959 - 1961

HAND-BOUND PERSONALIZED VOLUMES AVAILABLE ON ORDER

FOR $10.00 VOLUME — DELIVERY WITHIN 1 MONTH

by contacting Editor at 610 2nd Ave. — Anchorage, Alaska

MUKTUK MORSELS

A COLUMN DEVOTED TO MEDICAL NEWS IN ALASKA

Compiled by

HELEN S. WHALEY, M.D.

GENERAL:

On Friday November 15 a U.S. Public Health Service sponsored team of mental health experts visited the abandoned Army port of Whittier in order to determine whether it would be feasible to convert the facility into a state institution for juvenile delinquents and mentally retarded children as proposed by Health and Welfare Commissioner, Dr. Levi Browning. The Whittier installation which was in operation between 1954 and 1959 includes: the Buckner Building, a seven-story composite containing a bowling alley, 300-seat theater, 17-bed hospital, service clubs and lounges, rifle ranges, a television studio, chapels, quarters and messhalls; the Hodge building, a 14 story apartment building containing in addition an eight classroom school; a large power plant of 6,500 kilowatt capacity; a well-equipped gymnasium; and an equipment maintenance shop containing heavy duty snow removal and other vehicles. The port of Whittier, which is currently being maintained by 30 Army civilian employees, is located at the end of a mountain-locked fjord off of Prince William Sound 12½ miles from Portage and 62 miles from Anchorage and is connected to the main-line of the Alaska Railroad by a spur from Portage which traverses the intervening mountain range by means of two single-lane railway tunnels.

M. J. Dixson, Whittier maintenance superintendent, conducts (left to right) Mr. Robert Hayes, Dr. Levi Browning, Mr. Larry McDonald and Mr. Lloyd Morley through the power plant.

The visiting experts included: Allen Breed, Superintendent of the Preston School of Industry at Ione, California; Robert Hayes, Assistant Superintendent of the Pacific State Hospital at Pamona, California; Miss Naomi Kennedy, Mental Health Consultant in the U.S.P.H.S. from San Francisco; and Larry McDonald, U.S.P.H.S. architest from San Francisco. Local members of the inspection team included: Dr. Browning; Dr. Homer Ray, Acting Mental Health Director; Lloyd Morley, administrator of the Hill-Burton hospital program for the state; Dr. Thomas McGowan, South Central Regional Health Officer; Dr. William Eicker, newly appointed mental health planning coordinator; and Dr. John C. Tower, Anchorage pediatrician.

After continuing study and discussion, the group was expected to make its report to the United States Public Health Service by the end of November. Two other experts, Dr. Benedict Negler, Superintendent of the Lynchburg Training School at Colony, Virginia, and Dr. Jack Noone, engaged in research on mental retardation at the National Institute of Mental Health in Bethesda, Maryland, joined the group the weekend following the initial inspection trip, and visited the Whittier compound along with representatives of the Anchorage Medical Association.

An alcoholism workshop, entitled **A Symposium on the Problem Drinker** was held at the Anchorage-Westward Hotel on November 23 under the sponsorship of the Anchorage Committee on Alcoholism, the Anchorage Council of Churches and the Anchorage Mental Health Association. Visiting participants were Dr. Dan Anderson, a psychologist with the Hazelden Foundation in Minneapolis, and Mr. Richard Silver, Executive Director of the Seattle Committee on Alcoholism.

JUNEAU: Dr. Homer Ray, who has been acting as State Director of Mental Health on a temporary basis since the resignation of Dr. B. K. Smith in the fall of 1960, has asked to be relieved of these directorship duties. Dr. Smith plans to continue as practicing psychiatrist for the southeastern region, the position for which he was originally hired. Deputy Health and Welfare Commissioner Henry Harmon has announced that the state has stepped up its search for a new Director of Mental Health, a job paying $1,800 per month.

KETCHIKAN: A health center to provide out-patient services for Alaska natives, U.S. seamen and federal employees has been established on Annette Island, near Ketchikan. The center will provide full-time health services for about 1,800 Indians, Eskimos and Aleuts living on or near the island and for 230 federal employees working for the Federal Aviation Agency, the Weather Bureau and the Air Force. The approximately 70 residents of the island not connected with the federal government may receive emergency care on a fee basis. The decision to locate a full-time health center on the island site of the Ketchikan airport was made because weather conditions often make it impossible to take patients across the channel to Ketchikan by air or water. Dr. Roger Baumann, a native of West Bend, Wisconsin and a 1962 graduate of Northwestern University Medical School is the medical officer in charge. He will direct the center and the Coast Guard Clinic, also located on Annette Island, and will serve as a member of the Coast Guard Air-Sea Rescue Team.

Mrs. Jane Carr, president of the State Women's Auxiliary flew to Chicago in early October for the National Auxiliary Meetings.

PALMER: Dr. and Mrs. Arthur Colberg have left Palmer after many years of practice to spend a year with the Public Health Service on the remote Pribilof Island of St. George. J. R. Brown, M. D., formerly of Cordova, who is in the process of completing a surgical residency at the University of Utah, did a locum tenens for Dr. Hume while Dr. Hume and his wife attended medical meetings in the South Pacific and visited Australia, New Zealand, and Hawaii.

SOLDOTNA-KENAI: There is an active campaign underway to finance a hospital for this rapidly growing area of Alaska which now has three practicing physicians and a permanent industry in the form of a Standard Oil refinery.

Dr. Paul Isaak, Soldotna, President-Elect of the Alaska Heart Association, was the Alaska representative at the annual meeting of the American Heart Association in Los Angeles in October.

FAIRBANKS: Dr. George G. T. Leih is now associated with the Tanana Valley Medical Clinic doing general practice.

Dr. William H. James, after practicing briefly with the Tanana Valley Clinic has returned to Idaho.

Dr. Paul B. Haggland recently received the Silver Antelope award which is considered the highest attainable award in Boy Scout activities.

Drs. Henry Storrs and Arthur Schaible recently attended the meetings of the American College of Surgery and Dr. Schaible went on to the Pan Pacific Surgical Meetings in Honolulu, Hawaii. Dr. Haggland attended the Western Orthopedic Meeting in San Francisco.

Drs. Joseph Ribar, Joseph Johnson and Donald Tatum attended the clinical sessions of the American Medical Association in Portland in early December.

Ground will be broken for the new 120 bed St. Joseph Hospital in the spring of 1964 with completion planned for 1965.

ANCHORAGE: Dr. Charles St. John has been joined by Dr. Clyde F. Deal, formerly of Tulare, California and Meridian, Mississippi. Dr. Deal, a graduate of the Medical College of South Carolina in Charleston will do general practice.

Dr. Edwin C. Kraft has returned from a surgical residency in Harlan County, Kentucky, and is again associated with the Anchorage Medical and Surgical Clinic.

Dr. Thomas E. Kiester, formerly of The Doctors Clinic, is now in individual orthopedic practice in the Medical Arts Building on Northern Lights Blvd.

Dr. Robert Alzner, who was formerly with the Public Health Service in Anchorage, and briefly practiced anesthesiology on a private basis, is now associated with a large clinic group in Portland, Oregon.

Mr. Bruce Robinson has resigned as Administrator of Presbyterian Community Hospital and Dr. Stanley Rogers is leaving Alaska Psychiatric Institute to become Director of Mental Health for the State of Montana.

Dr. Milo Fritz continues to hold itinerant EENT clinics in Fairbanks, St. Mary's, and southeastern Alaska. Dr. Mahlon Shoff now holds regular EENT clinics in the Kenai-Soldotna area.

A number of medical meetings have been attended by local physicians. Dr. Merritt Starr went to a post-graduate course at the University of Washington. Drs. William J. Mills Jr. and Rodman Wilson participated in the Northwestern Rescue Group Meeting in Seattle on frostbite. Drs. Fred and Louise Ormond Hillman attended the American College of Surgeons. Dr. John Tower attended the North Pacific Pediatric Meeting in Victoria, B.C. in late September and Drs. Helen Whaley and George Sperry participated in the American Academy of Pediatrics meetings in Chicago in October. Dr. Charles Chenoweth attended his annual refresher courses in otolarygology and ophthalmology in Iowa. Drs. Asa Martin and Lester Margetts and their wives participated in the Pan-Pacific Surgical Association Conference in Honolulu. In the absence of Dr. William J. Mills, Jr., Dr. Margetts presented his paper on frostbite. Dr. Royce Morgan attended the Cancer Society meetings in New York. Dr. Duane Drake attended a refresher course in radiology in the midwest in November. Dr. Elizabeth Tower, Editor of Alaska Medicine, participated in the Annual Meeting of the American Medical Writers Association in October in Chicago, where she also attended sessions at the American Academy of Pediatrics meetings.

ANS NEWS: A field (M.O.C.) conference was held at the ANS Hospital October 21-28, which was chairmanned by Drs. Holman R. Wherritt, Area M.O.C., and George Wagnon, M.O.C. at Mt. Edgecumbe. One of the major emphases was on the health program on the village level. It was hoped by focusing attention to the level where the Native health problems begin that more preventive medical care could be offered. In addition, there was considerable emphasis about interagency relationships, including Bureau of Indian Affairs; Division of Indian Health; Alaska Department of Health (including Mental Health, Public Welfare and the State Laboratory); Office of Vocational Rehabilitation; and Arctic Health Research Center.

Dr. George Sperry, Pediatrician at the Anchorage ANS Hospital, recently became a diplomate of the American Board of Pediatrics.

ANNOUNCING
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SATURDAY, FEBRUARY 22, 1964—Morning and Afternoon Sessions
Anchorage-Westward Hotel, Anchorage, Alaska

Some Observations in Jaundiced Patients with Partial Biliary Obstruction
Roger Williams, M.D., Professor of Surgery, Ohio State University Medical School, Columbus, Ohio

Hashimoto's Thyroiditis and it's Immunological Aspects
Leslie DeGroot, M.D., Department of Internal Medicine, Harvard Medical School, Boston, Massachusetts

The Effect of Long Term Steroid Administration on Hypothalamic-Pituitary-Adrenal Function
Nicholas Christy, M.D., Department of Internal Medicine, Columbia University Medical School, New York, New York

MODERATORS: Morning Lectures—Don Val Langston, M.D.
Luncheon—Royce Morgan, M.D.
Afternoon Discussions—Glenn Crawford, M.D., for Dr. Williams
Rodman Wilson, M.D., for Dr. DeGroot
Winthrop Fish, M.D., for Dr. Christy
Ladies' Activities — Mrs. Francis Phillips

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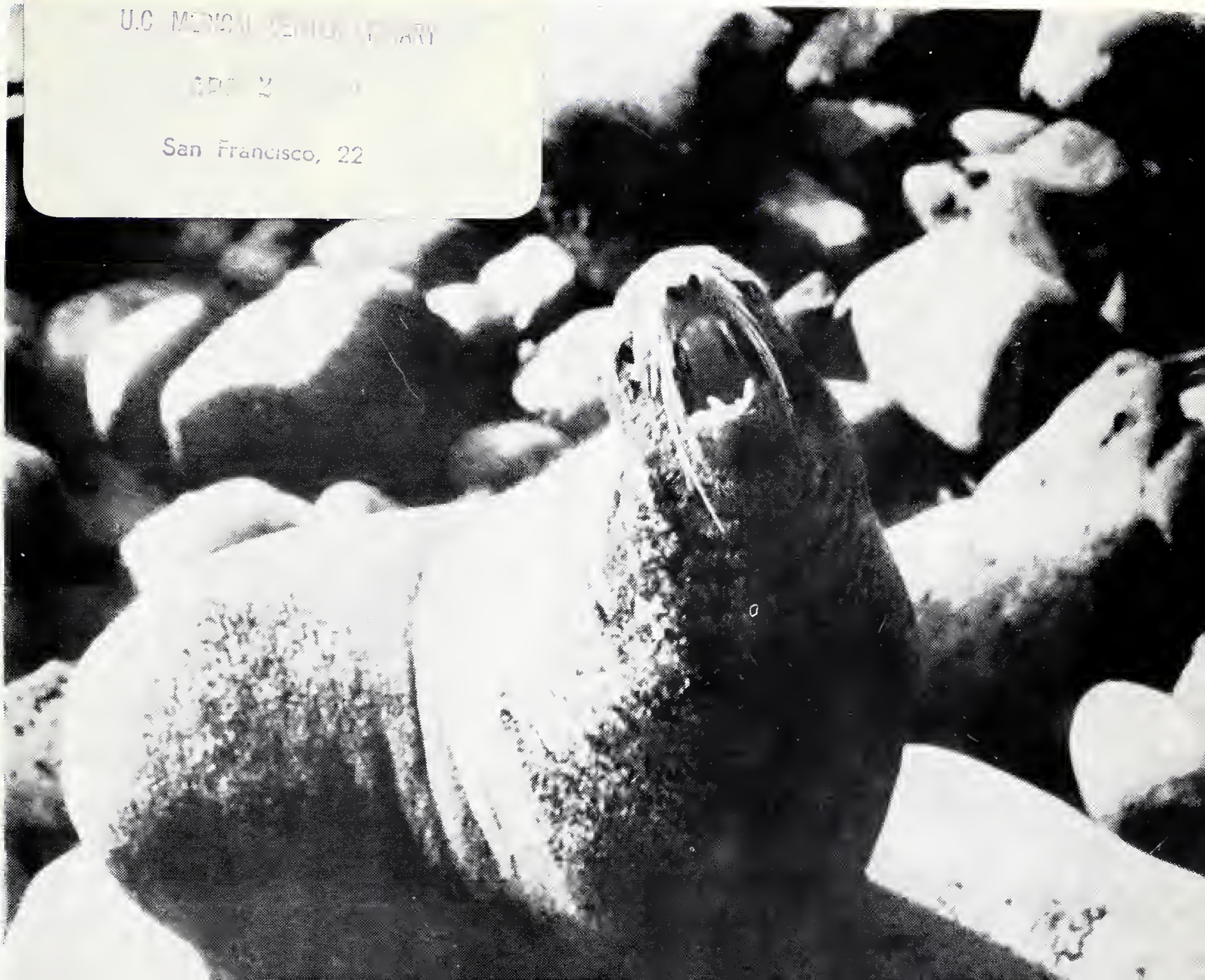

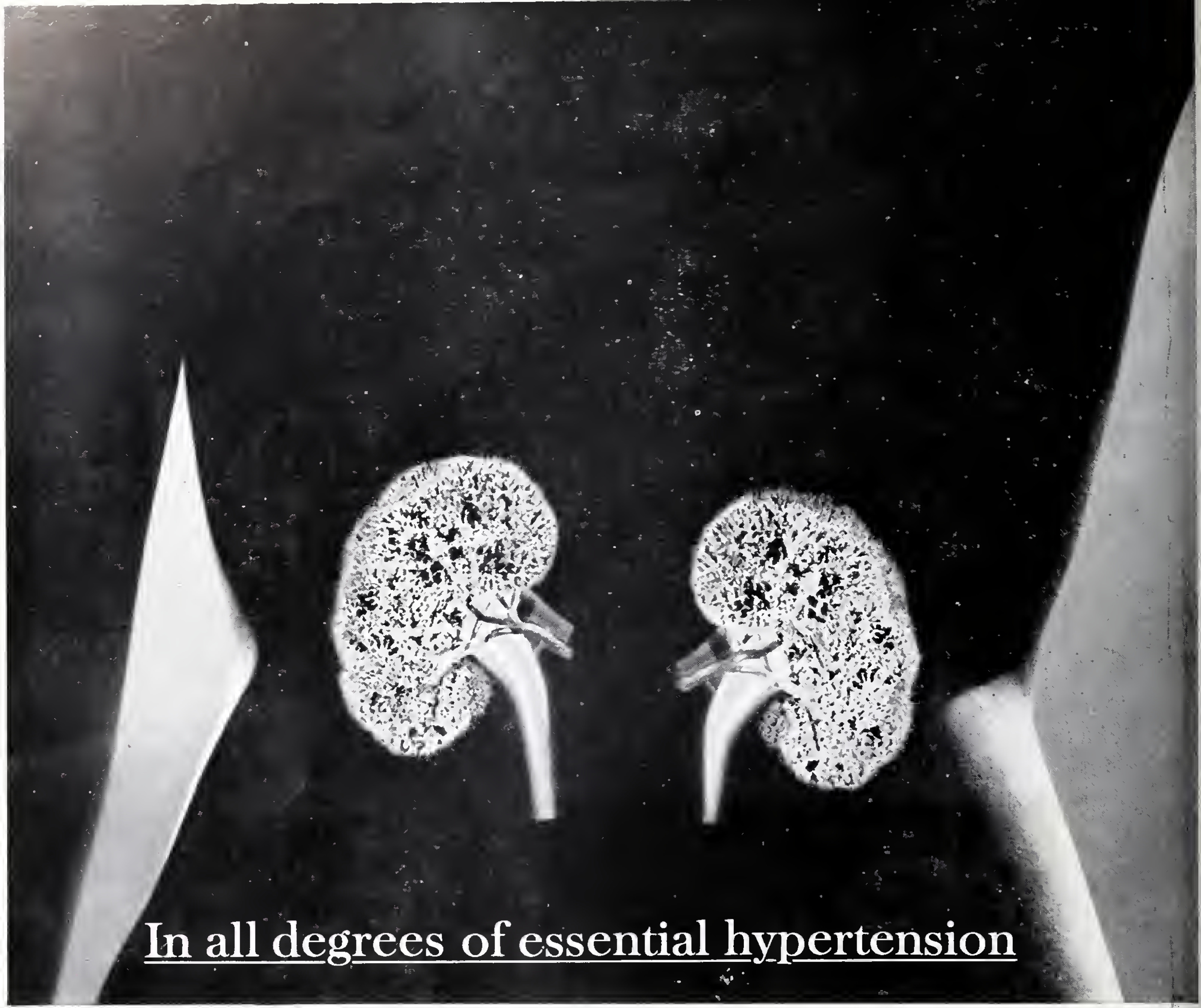
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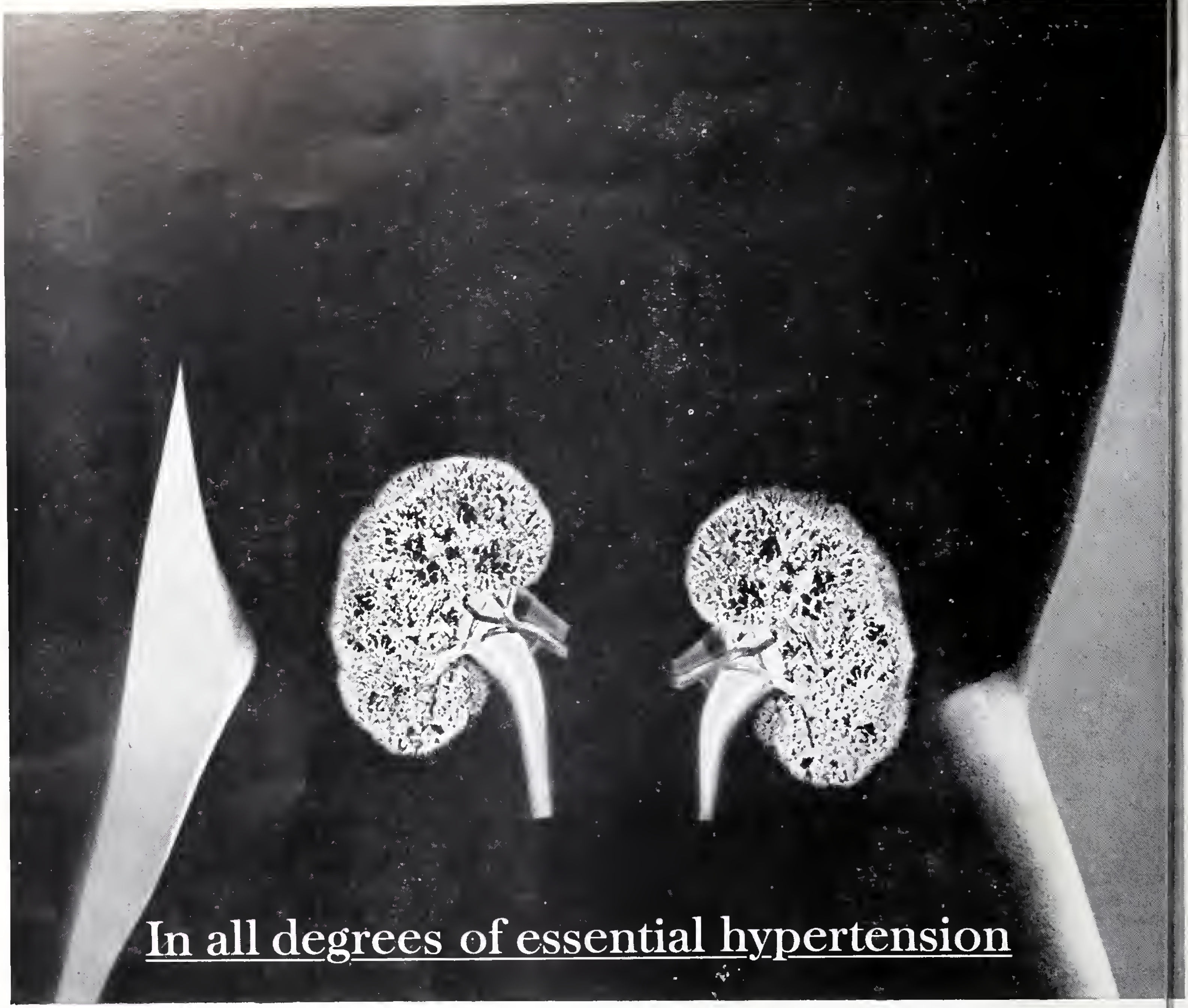

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NOTES ON THE EPIDEMIOLOGY OF DRAINING EARS AND HEARING LOSS IN ALASKA WITH COMMENTS ON FUTURE STUDIES AND CONTROL MEASURES

by

JACOB A. BRODY, M.D.

Chief, Epidemiology Section, Arctic Health Research Center, U. S. Public Health Service, Anchorage, Alaska

Dr. Brody

Middle ear pathology is a problem of unusual magnitude for Alaskan physicians. Various studies [1, 2, 3] report hearing loss in up to 14 percent of Caucasians and 34 percent of Eskimos, and evidence of chronic otitis media in about one-third of Alaskan Indian, Aleuts and Eskimos. Although statistics are not available from other states or countries for comparison, it is the rare Alaskan physician in private practice, in military service, with the Public Health Service, or with the Alaska Department of Health who is not aware that we see an inordinate number of cases of acute and chronic otitis media.

During the past year a series of small pilot projects was conducted among various Alaskan populations by the Arctic Health Research Center in order to develop some epidemiological concepts of middle ear disease. Part of these studies will be published shortly [4]. In this report, I would like to review some of our data and thoughts concerning the middle ear problem and also discuss possible avenues for determining cause and evolving methods of prevention and control.

Summary of Recent Investigations.

Surveys to determine the incidence of hearing loss and history of ear pathology were conducted in seven Eskimo villages in the Bethel area and for comparison similar investigations were conducted on St. Paul Island where the population is primarily Aleut and in Wasilla where the majority of the people are Caucasians. The entire population up to age 20 was included in the Eskimo villages and on St. Paul, while in Wasilla we studied a 20 percent sample. In addition, we conducted a small study of children of teachers who reside in native villages in Alaska and of children of school teachers living in other states.

1. History of draining ears.

History of acute otitis media or earache was not accurate and varied considerably among the persons interviewed. We found, however, that history of draining ear at any time in the past was well reported by most groups. Thirty-one percent of Eskimo children had history of draining ears at some time in their life. Twenty percent of children in Wasilla had had draining ears; while among St. Paul Island residents, 11 percent had draining ears. The rate for Alaskan teachers' children was 8 percent while for teachers' children in other states it was 15 percent. Data collected during an Infant Morbidity and Mortality Study in 27 Eskimo villages in the Bethel area

Table 1

HISTORY OF DRAINING EAR IN ALASKAN AND NON-ALASKAN POPULATIONS

			History of Draining ear	
Series	Ethnic group	No.	Never %	One or more times %
Wasilla	C	103	80	20
Alaskan teachers' children	C	162	93	7
Non-Alaskan teachers' children	C	99	85	15
St. Paul, Pribilof Islands	A	95	89	11
7 Eskimo villages	E	1003	69	31

* C—Caucasian A—Aleut E—Eskimo

revealed that 38 percent of Eskimo children suffered at least one episode of draining ears by the end of their first year of life [5].

2. Hearing loss.

We defined severe hearing loss as loss of 40 decibels or more from 1000 to 3000 cycles per second, and normal hearing as no loss of 20 decibels from frequency of 500 to 6000. By these standards, 13 percent of Eskimos tested had severe hearing loss, while only one percent of St. Paul Island residents and of residents of Wasilla had severe hearing loss (Table 2).

Table 2
HEARING LOSS IN VARIOUS ALASKAN POPULATIONS

		Optometer rating	
Series	**Ethnic group**	**Total**	**Severe loss* %**
Wasilla	Caucasian	244	1
St. Paul, Pribilof Islands	Aleut	87	1
Eskimo villages	Eskimo	327	13

*Loss of 40 decibels or more from 1000-3000.

3. Relationship between draining ears and severe hearing loss.

A very close correlation was demonstrated among Eskimos with no history of a draining ear and the absence of severe hearing loss. Of 188 Eskimos who denied ever having suffered a draining ear, only 3 percent had severe hearing loss. A strong correlation was also found between those having a severe hearing loss and those with a positive history of draining ears with 86 percent of all those with severe hearing loss having history of draining ears.

4. Rates of draining ears by age.

A most striking finding in our studies was that, regardless of age, the percent of children having draining ears at some time in life was almost the same (Table 3). Of 1003 Eskimos studied approximately one-third of any age group had a history of at least one episode of draining ears. Thus, about one-third of those age 15 to 19 had history of draining ears and about one-third of those age 0-3 had similar histories. This is remarkable, since with most infectious diseases the percent of the population which has suffered an illness increases with age.

Table 3
PAST HISTORY OF DRAINING EAR AMONG ALASKAN ESKIMOS BY AGE GROUP

		History of draining ears - %	
Age group	**Total**	**Never**	**One or more times**
0-3	246	66	36
4-8	273	67	33
9-13	229	69	31
14-18	136	72	28
19 & over	119	76	24
Totals	1003	69	24

5. Relationship between oral pathology and ear pathology.

In the village of Hooper Bay, an interesting correlation was found between the number of decayed, missing or filled teeth (DMF rating) and ear pathology measured either by history or audiometry (Table 4). To date, we have not had an opportunity to extend these studies to other villages.

Table 4
COMPARISON BETWEEN ORAL PATHOLOGY* AND EAR PATHOLOGY IN HOOPER BAY†

DMF Rating	Number of cases	Ear Pathology, %
1-5	433	37
6-10	55	42
11 »	37	51
Total	135	43

*Determined by total decayed, missing or filled teeth (DMF rating).
†Determined by history and otometry.

Discussion.

The most important concept that is emerging from our work is that chronic otitis media is established in approximately one-third of the population in Eskimo villages within the first year or two of life. Presumably this one-third continues to have episodes of draining ears as it ages and accounts for well over 80 percent of all severe hearing losses. The remaining two-thirds of the population which does not develop draining ears by the first year or two of life apparently runs little risk of developing chronic otitis media later in life. In our series only 3 percent of these people had severe hearing loss.

Two British studies [6, 7] support our findings, emphasizing that acute otitis media occurs most frequently in infancy and that with each attack the likelihood of a subsequent attack increases.

There is a curious parallel between chronic otitis media and hearing loss and rheumatic fever and rheumatic heart disease. We now know that rheumatic fever is caused by streptococcus and that a certain percent of cases with rheumatic fever will subsequently develop heart disease. Further, we know that a person who has suffered an attack of rheumatic fever has an increased risk to subsequent infection with streptococcus and subsequent rheumatic fever which in turn increases risk of developing heart disease. Finally, the chances of developing rheumatic heart disease are markedly less in the absence of rheumatic fever than in its presence. Management of patients with rheumatic fever is based on a continuous regimen of antibiotics or chemotherapeutics designed to prevent reinfection with streptococcus. Once a person has rheumatic fever, management must be prophylactic and continuous.

Our studies indicate that acute otitis media with draining ears occurs in about one-third of the population at a very early age. Once the infection occurs its likelihood of reoccurrence increases with each successive bout. The overwhelming majority of those with severe hearing loss have chronic otitis media. Control measures must therefore be directed toward establishing a regimen which prevents the infection of the middle ear once an infant has shown himself disposed to these infections, i.e., after an infant has suffered his first bout of draining ears. Apparently, application of therapeutic measures during attacks are not sufficient to control the process. In England [7.] treatment failures were in the neighborhood of 30 percent and under existing conditions in most Eskimo villages, treatment failures occur with depressing frequency.

I would like to suggest certain studies, both of etiology and control, some of which we at AHRC are capable of doing but the majority of which are beyond our resources. Specific areas of investigation are:

1. The role of viruses in precipitating acute otitis media. This can be investigated either through virological studies, which are extremely difficult and costly in distant areas, or through comparative serological tests which, while cumbersome and expensive, are feasible.

2. The role of bacteria in both acute and chronic otitis media and determination of the relationship between throat flora and ear flora. This type of study should be done in major population centers or universities where adequate facilities for collection and handling of specimens exist. It is disheartening to read the literature and realize that even today it is not known whether throat flora and organisms in the middle ear during an attack of otitis media are the same, and more important, to know if one can treat otitis media on the basis of cultures and sensitivities from throat swabs.

3. The role of allergy. This could be well studied in Alaska since we have sufficient clinical material for the complicated analysis entailed.

4. The role of heredity and family predisposition.

5. The role of geographic area, season, race and variations in pathology among villages which may give clues to the etiology of otitis media.

6. The very interesting suggestion that oral pathology and ear pathology may be related.

While defining the etiology is, of course, most essential and urgent, I do not feel that ready answers will be available for some time. Certain clinical trials should, therefore, be instituted as soon as possible. Clinical trials must be carefully controlled. In Alaska we have a unique opportunity for performing such trials since there are very few accessible populations elsewhere where one-third of children will have draining ears by age one. Several regimens come to mind which should be evaluated as the cornerstone for long-term control of ear infections. Among them are:

1. Early adenoidectomy. Recent studies by McKee [8, 9] showed that removal of adenoids was the relevant factor in lowering the frequency of otitis media and that the tonsillectomy added greatly to the risk of surgery while very little to the result. He further showed that the operation had by far the best results when performed in very young children.

2. Long-term antibiotic or chemotherapeutic therapy. Although most reports have been discouraging concerning the prevention of otitis media by prophylactic antibiotics, a definitive study has yet to be done. As I mentioned before, there are very few populations with attack rates sufficiently high to evaluate methods of prophylaxis for otitis media. I think several antibiotics or chemotherapeutics and different regimens should be tried.

3. Vaccines against respiratory viruses. Every attempt should be made to identify the respiratory viruses which are prevalent in Alaskan infants under age two or three. These probably do not differ greatly from the major viral pathogens in other areas which are the adenoviruses, respiratory syncytial virus, and the parainfluenza viruses. Measles and influenza are less frequent and more remarkable when they appear. The newer group of common cold viruses

now numbering into the hundreds must also be considered. Many vaccines are now under investigation and a few are actually available for certain of the respiratory disease viruses. As appropriate vaccines become available, they deserve field trials in Eskimo villages.

4. Other notions. Perhaps the prolonged use of anti-inflammatory or antihistaminic agents deserves a field trial. Another thought is use of small doses of gamma globulin at regular intervals which, at least in one recent study, had a remarkable effect on reducing respiratory symptoms among allergic children [8].

I believe it is important to emphasize that otitis media is a disease which in Eskimos starts at a very early age, and that each attack increases the likelihood of subsequent attack. The solution we seek should be prophylactic and directed toward preventing subsequent attack once the illness is established in an individual. It would be nice, indeed, if we could pinpoint the etiology to a simple pathogen, such as streptococcus in rheumatic fever. Then a prophylactic regimen could be rapidy and directly instituted. Our problem, however, is many sided, and perhaps several solutions will evolve, each with its own limited application. In the long run, methods for preventing even initial attacks may be available. For the time being, however, we have a relatively simple means of defining the population in which the greatest amount of subsequent hearing loss will occur which may provide the necessary approach to this immensely difficult problem.

Summary.

Data concerning hearing loss and history of draining ears were analyzed for a large group of Alaskan Eskimos and smaller populations of Aleuts and Caucasian Alaskans. The rate of chronic otitis media and hearing loss was very much higher among Alaskan Eskimos than other groups tested. A strong correlation was shown between history of draining ear and hearing loss. The results suggest that ear pathology is established in approximately one-third of the Eskimo village population by about age two and that this group may comprise the population which later develops severe hearing loss, while those who by age two have not had draining ears are unlikely to develop ear pathology in subsequent years. Each instance of otitis media increases the likelihood of subsequent attack. The basic concept is advanced that control of otitis media and subsequent deafness among Eskimos demands that infants who have draining ears be put on a prophylactic regimen analogous to the use of antibiotics and sulfa drugs for prophylaxis in rheumatic fever cases. Simply treating each acute episode is of limited value.

ACKNOWLEDGMENTS

I gratefully acknowledge the nurses with the Bethel Field Unit of the Arctic Health Research Center, Catherine Haley, Mary Lou Heminghous, Earline Isabel, Nancy Wetmore; and Irvin Emanuel, M. D., Senior Fellow, Department of Preventive Medicine, University of Washington School of Medicine for their part in collecting these data; and to Theresa Overfield, R.N., M.P.H. and Robert McAlister, M.D. of the Epidemiology Section of the Arctic Health Research Center go my thanks for their help in compiling and analyzing the results.

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ALASKA 1963 ORAL CANCER SURVEY

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Although tumors are not the most common oral pathological condition, they do have a profound effect upon the patient and his longevity. It is the responsibility of the dental profession as guardian of the oral cavity to be alert, informed, and suspicious of all oral lesions.

It is not enough to state, "I am not sure, but we'll watch it." Time is of the essence. Patient delay in seeking advice, professional delay in making diagnosis, and the combined delay in extending adequate treatment only increases the chance of a fatal prognosis.

Tumors are hyperplastic swellings of the tissue and indicate an abnormal condition. Although all tumors are not magninant, all hyperplastic conditions should be viewed with suspicion. Swelling and tissue changes indicate an irritant which should be eliminated before an irreversible lesion has developed and a radical approach becomes mandatory. If, as many researchers believe, malignant neoplasms develop only after repeated insults to the tissue and during this time many physical and chemical changes are present, it is imperative that the profession and the public alert themselves to these changes. If patient and professional indifference is the greatest cause of unfavorable cancer prognosis and not the disease per se, then steps must be taken to stimulate the patient and profession to be alert for precancerous lesions. Because of the above premises, the Alaska State Dental Society, the dentists of the PHS Alaska Native Health Program, and the Alaska Medical Laboratories cooperated with the Alaska Division of The American Cancer Society in presenting the first state-wide oral cancer examination. The purpose of this examination was threefold: 1) stimulate the public and professional awareness of oral lesions, 2) diagnose potentially cancerous lesions and initiate treatment, and 3) biopsy questionable lesions and see that all malignant neoplasms receive immediate treatment. This examination included visual and palpable evaluation and biopsy where indicated. Only a small laboratory fee for tissue examination was charged to the patient if biopsy was required.

Review of the oral examination shows that its objectives were accomplished. The success was limited in that only one person out of every two hundred fifty people in the state of Alaska presented himself for the evaluation. Two dentists felt themselves unqualified as diagnosticians and referred their patients to other examiners. All but one dentist felt that the examinations were beneficial and expressed their willingness to cooperate in future oral cancer programs.

Number of Patients Seen

The report revealed that 56% of the 1,097 patients seen were females. The ages of the patients examined ranged from one to ninety-one. Many of the patients fell into the seven to fourteen age group because several public health dentists examined all school children in their villages. The total examinations in other age groups are fairly consistent until fifty-seven years of age at which time the number of examinations dropped rapidly. The total number of male and female patients is less than the number of examinations recorded because some dentists failed to report the gender of their patients.

Number of Lesions

Of the 185 lesions reported, ninety-two or 49% of these lesions were considered to be precancerous, or the result of chronic irritation that unless remedied might lead to precancerous changes. If a patient possessed more than one type of lesion, each was counted separately. Lesions were recorded in 16.9% of the patients seen; however, because some dentists listed only premalignant lesions, the total number of benign lesions may be greater in the average population. The number of lesions is fairly consistent when compared with the number of examinations. More lesions were seen in females (94) than males (84); however, more females were examined. When computed in the basis of lesions per hundred, we find that females had 16.7 and males 19.5 lesions per hundred. Potentially cancerous lesions were evenly divided between sexes with 8.9 per hundred in females and 9.0 in males. There were twenty-nine different types of lesions recorded; three were precancerous, five were potentially precancerous, and one malignant.

CLASSIFICATION OF ORAL LESIONS

MALIGNANT	**Female**	**Male**	**Total**
Squamous cell carcinoma	1	0	1
Total	1	0	1
POTENTIALLY MALIGNANT			
Epulis fissuratum	4	5	9
Hemangioma	4	2	6
Hyperkeratosis	11	12	25
Hyperplasia	16	12	29
Leukoplakia	0	1	1
Linea alba	3	0	4
Papillomatosis	4	2	6
Traumatic ulcer	7	5	12
Total	49	39	92
BENIGN			
Allergic response	2	0	2
Cellulitis*	2	0	4
Cyst, bone residual	1	3	4
Fibroma	5	2	7
Fistula	2	4	6
Fordyce granules	0	6	6
Foreign body	1	0	1
Gingivitis	1	0	1
Hematoma	1	1	2
Herpes simplex & stomatitis	2	2	4
Keloid	1	0	2
Lichen planus	1	1	2
Lymphadenitis*	1	1	2
Monilial fungus	0	1	1
Mucocele	0	1	1
Papilloma	12	14	26
Periodontoclasia	1	1	2
Phargynitis*	1	0	1
Ranula	1	0	1
Torus mandibularis	0	1	1
Torus palatinus	5	4	9
Varicocele	0	1	1
Undiagnosed lesions	4	1	5
Total	44	45	92
Grand Total	94	84	185

*Not true lesions

The number of total lesions is greater than those listed under sexes because two dentists failed to list the gender of their patients.

All lesions which have a tendency to develop into cancer were included in the premalignant group. X-rays were taken for evaluation of swellings or fistulas and not as a routine part of the examination.

In this report no white lesion was listed under leukoplakia unless diagnosis was sustained with a biopsy. The reports revealed a wide variation of treatment for those lesions which were diagnosed.

Treatment of Potentially Malignant

Observation	32
Treatment recommended	17
Biopsy	39
Referred to Dentist	9
Referred to Physician	9

Several dentists indicated patients with lesions had been under symptomatic treatment or observation for the past one to three years, i.e. bone cysts, leukoplakia, epulis fissuratum, papillomatosis, etc.

Hyperkeratosis. Although white lesions of the oral cavity are usually benign, there appears to be considerable confusion as to their diagnosis and treatment. All white lesions present hyperkeratosis. Hyperkeratosis refers to the abnormal thickening of the keratin layer of the epithelium resulting in a typical whitish appearance of the mucosa. This thickened keratin is caused by an irritant and will usually return to normal tissue if the irritant is removed. If the irritant which caused the hyperkeratosis is not removed, this lesion may develop into leukoplakia. Leukoplakia differs from hyperkeratosis in that it presents dyskeratosis, a condition in which a number of abnormal cellular characteristics are found in the keratin layer. These cells present many aberrations which are common in malignant neoplasms; such variations and abnormalities can be detected only with cellular studies. Therefore, for a positive identification of leukoplakia, a biopsy with subsequent microscopic examination is essential. Leukoplakia is not reversible, and will not return to normal. healthy tissue. It should not be observed except under extreme circumstances. Tissue progresses through the following stages: hyperkeratosis—hyperkeratosis with dyskeratosis (leukoplakia)—squamous cell carcinoma. Hyperkeratotic lesions should be treated before dyskeratosis develops. Leukoplakia must be excised to prevent oral carcinoma; it is a premalignant lesion and even multiple negative biopsies should not permit the diagnostician to relax. Diagnostic procedures and treatment should progress simultaneously.

Discussion. It was not the aim of this examination to make a pathologist or diagnostician out of every doctor, but to encourage the profession to familiarize itself with normal and abnormal tissues. The profession is responsible to the public to be mentally and physically equipped to diagnose these lesions or to take the responsibility in forwarding the patient to the most competent individual for evaluation. The greatest weapon against oral cancer is an alert and informed public and profession. It is important that both the profession and the public realize many potentially cancerous lesions exist in the oral cavity, and if permitted to go untreated, either because of indifference or unawareness, a cancer fatality may be created.

There was no record of the race of persons examined, however, it is estimated that one-third or more were native. It would be interesting to learn whether a greater percentage of lesions are found in one race over another; any similar comparison is unknown at the present time.

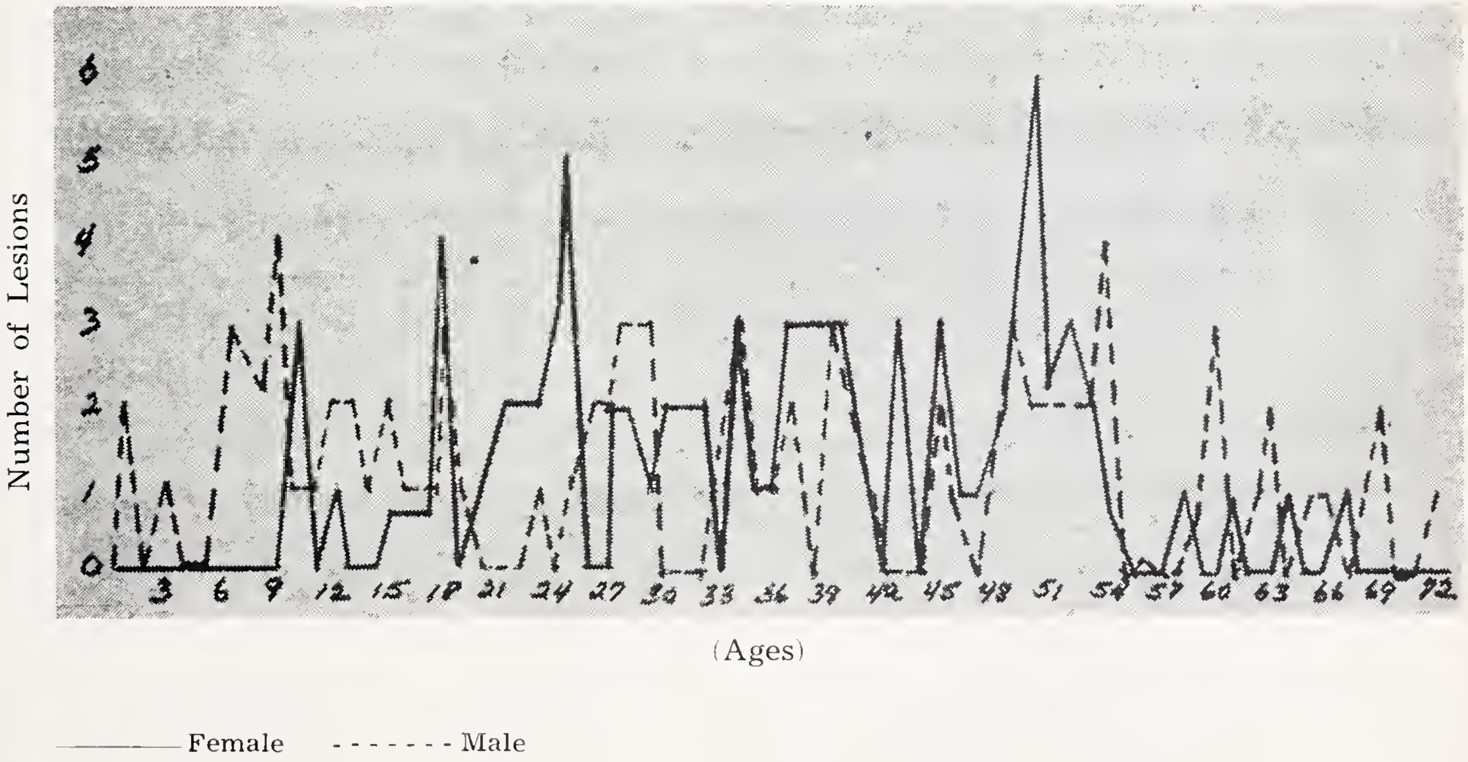
It is also interesting to note that all potentially cancerous lesions were directly related to either physical or chemical trauma. Approximately 50% of these lesions were secondary to the wearing of partial or full dentures.

One physician reported that he had several requests for cancer examinations over other areas of the body, and the patients stated that their requests were prompted by oral cancer publicity. This unplanned benefit is highly desirable.

One squamous cell carcinoma is under radiation treatment at Virginia Mason, and prompt action by her dental examiner and local physician may contribute to favorable results.

Another state at the time of this writing has requested information with the intention of planning a similar program during the coming year.

Summary. State-wide oral examinations revealed the need for professional review of oral lesions and their treatment. Additional efforts should be made in the future to increase the number of examinations and the quality of the reports. Many lesions do exist in the oral cavity in those patients that are seen daily by the dentist and the physician. Some of these lesions are potentially cancerous and early recognition and treatment is important. There were 1,097 examinations and 8% of these patients presented potentially cancerous lesions. No definite conclusions should be made from the enclosed figures because each group is too small; however, by compiling and comparing these figures with future years, trends and meanings can be given to these figures. The dentists of Alaska have agreed to assist in future examinations, and it is felt that this should become an annual program.



RADIOISOTOPE SCANNING

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Dr. Coin

Medicine has benefitted — as have other arts and sciences — from the extensive research in nuclear physics for military purposes which had its inception prior to World War II. The development of the subspecialty of nuclear medicine and of the myriads of clinical radioisotope tests is a byproduct of the continuing research in radiobiology, radiation physics and in basic electronic instrumentation. The clinical usefulness of many, perhaps most, radioisotope procedures and techniques is still in the process of evaluation. This is the expected state of affairs in view of the large number of variables encountered in any in vivo laboratory test with a given radioisotope. Interest and opinion as to the value of these tests varies from none at all to extreme overenthusiasm. My own general opinion is that, as so often develops, few of the isotope procedures have replaced established clinical laboratory diagnostic tests but rather the isotope studies have extended the range of more conventional tests. It is axiomatic that these radioisotope tests, like all laboratory tests, do not substitute for mature clinical judgment. Even a markedly elevated thyroid uptake is not pathognomonic of hyperthyroidism but must be evaluated in its clinical context.

The purpose of this paper is to acquaint Alaska physicians with some of the radioisotope scanning procedures which are currently available in the State and to attempt to give the current consensus as to the usefulness of the specific scan discussed. No attempt will be made to discuss the radioisotope uptake, dilution or life-span studies or to discuss radioisotope therapy.

DEFINITION

Radioisotope organ or area scanning is a procedure in which a radioisotope labelled compound or element is administered to a patient and this is followed, after a variable time interval, by detection and photographic recording of the location and concentration of the labelled compound in the organ. The resultant "scan" is a series of parallel dots of varying density on X-ray film which is physically or photographically superimposed on a conventional radiograph of the part.[4] Alternately, as in thyroid scans, the dot scan is oriented to the patient by inspection and palpation.

MECHANISM OF ACTION

Radioisotope study of human physiology is possible since a radioactive atom is metabolized by the body along exactly the same biochemical pathway as a nonradioactive atom of the same atomic species. The radioactive atom periodically emits gamma rays (or other rays or particles) which can be readily detected by currently available electronic equipment. If large numbers of radioactive atoms are considered this emission of gamma rays occurs over a finite time which is characteristic of the isotope in question; this time is most conveniently expressed as the "half-life" or T½ of the isotope. This is the time interval during which one half of the original number of radioactive atoms have decayed.[1] At the completion of this decay the original radioactive atom becomes a nonradioactive or stable atom of another element. For example Iodine^{131} after decay with a half life of approximately eight days becomes a stable isotope of Tellurium.

In the process of radioactive decay I^{131} emits a spectrum of gamma rays and negative beta particles of which the principal gamma ray utilized in clinical detection is the 0.365 mev gamma.

INSTRUMENTATION[13]

The scanning unit consists of a 3 inch diameter by 2 inch deep thallium activated sodium iodide crystal which is heavily shielded with lead and the mechanical and electronic devices needed to move this probe, translate the light scintillations to electrical pulses and record them on film. The scintillation crystal is optically coupled with a photomultiplier tube and the photomultiplier tube connected to a preamplifier, these, with the lead shielding are referred to as the "probe." In front of the crystal of the probe is a collimator consisting simply of a lead block with accurately drilled holes to "focus" (actually converge) on the crystal surface. This probe is moved at constant speed (which can be varied) over the area of the patient scanned.[4] The electrical impulses produced by the probe (which result from the gamma rays emitted by the radioisotope in the patient) are then conducted thru shielded cables to the electronic circuits of the scanning unit. Within the scanning unit the electrical pulses are sorted, shaped, some rejected, others amplified and selected pulses utilized to appear at the output side of the scanner in two forms: first, an immediately appearing dot scan on heat sensitive paper; second and simultaneously, an exposure of an x-ray film. The dot or paper scan is useful in positioning the patient during scanning but also has some diagnostic value. The photographic scan is the definitive scan used for diagnosis.

PULSE PATH IN THE SCANNER[13]

The weak electrical pulse from the probe is "fed" first to a very stable linear amplifier. From the linear amplifier the pulse is sent to the pulse height analyzer. This unit permits rejection of electrical pulses above and below the voltage which results from the gamma rays of the radioisotope selected. For example: the unit can be set to reject all electrical impulses resulting from gamma rays below 345 Kev and all resulting from gamma rays above 395 Kev. This allows good resolution of the principal gamma ray of I^{131} which is 365 Kev. The pulses resulting from this pulse height amplifier then actuate a cathode ray type of light source so that very accurate density light pulses can be utilized to expose the x-ray film. The scan density and sharpness can be varied in a number of ways by electronic controls. For example the contrast can be varied by a "range differential" control, the density by a density control (which regulated the light pulse duration to pulse ratio), the scan speed, etc.

FURTHER CONSIDERATION OF PULSE PATH

The pulse from the pulse height analyzer is accepted by a distribution analyzer which in turn drives the counting ratemeter, the dot recording and scale down circuit, and the photorecording density circuit. The ratemeter develops a voltage analog to counting rate which is used to drive the howler (audio tone for hand scanning), background cutoff control, and to modulate the accelerating grid voltage of the photorecording cathode ray tube. The background cutoff control affects only the dot scan. Each and every detector pulse accepted by the pulse height amplifier produces an exposure on the photorecording film. The density of these exposures is controlled both by the counting-rate modulated accelerating grid voltage of the cathode ray tube, and by the setting of the density control. The degree of contrast enhancement in the film is adjusted with the range differential control. This control varies the gain of the amplifier which is in turn controlled by the count rate and controls the cathode ray tube accelerator voltage.

THYROID SCANNING

Most of the early work was on scanning the thyroid gland after administration of radioactive iodine. A good review of this subject as well as extensive references for further reading is found in Silver[2] page 76. The most frequent indication for a thyroid scan is the evaluation of thyroid nodules. A "hot" nodule, that is one which concentrates significantly more iodine than the surrounding gland, is almost certainly benign — although a few malignant "hot" nodules have been reported. Practically all of the malignant lesions occur in "cold" nodules although the incidence of malignancy in a given "cold" nodule is low. Other indications for thyroid scanning include the evaluation of patients with known functioning thyroid malignancy for residual tumor and distant metastases following total thyroidectomy; the search for functioning thyroid tissue in ectopic locations such as the base of the tongue; identification of the rare struma ovarii.

Illustrative Case No. 1

The patient, a 21 white female, had clinical symptoms which were suggestive of hyperthyroidism and a questionably nodular thyroid gland. The thyroid uptake was 35% which is within the upper limits of normal. The scan shows uniform normal distribution of iodine in the gland.

Illustrative Case No. 2

D.S., a 13 year old white girl, was noted to have progressive enlargement of the thyroid gland, particularly the left lobe. The gland felt hard and multinodular. The thyroid uptake was 30.5% which is normal. The scan shows a relatively normal appearing right lobe in its upper half. However the curvilinear, concave indentation along the outer aspect of the right lower lobe is a cold nodule. The left lobe is grossly abnormal and is in general hypofunctioning, enlarged and has poorly defined margins. These findings indicated the definite risk of malignancy. Fortunately, however the gland was benign at surgery.

Illustrative Case No 3

K.M., a 46 white woman who had had a right subtotal lobectomy earlier, presented with a palpable nodule at the level of the thyroid cartilage. The patient was taking thyroid medication which suppressed the iodine uptake to 15%. However sufficient iodine was concentrated in the gland to obtain a satisfactory scan. The scan shows absence of the upper half of the right lobe from previous surgery. The concave defect along the medial margin of the left upper lobe represents a "cold" nodule.

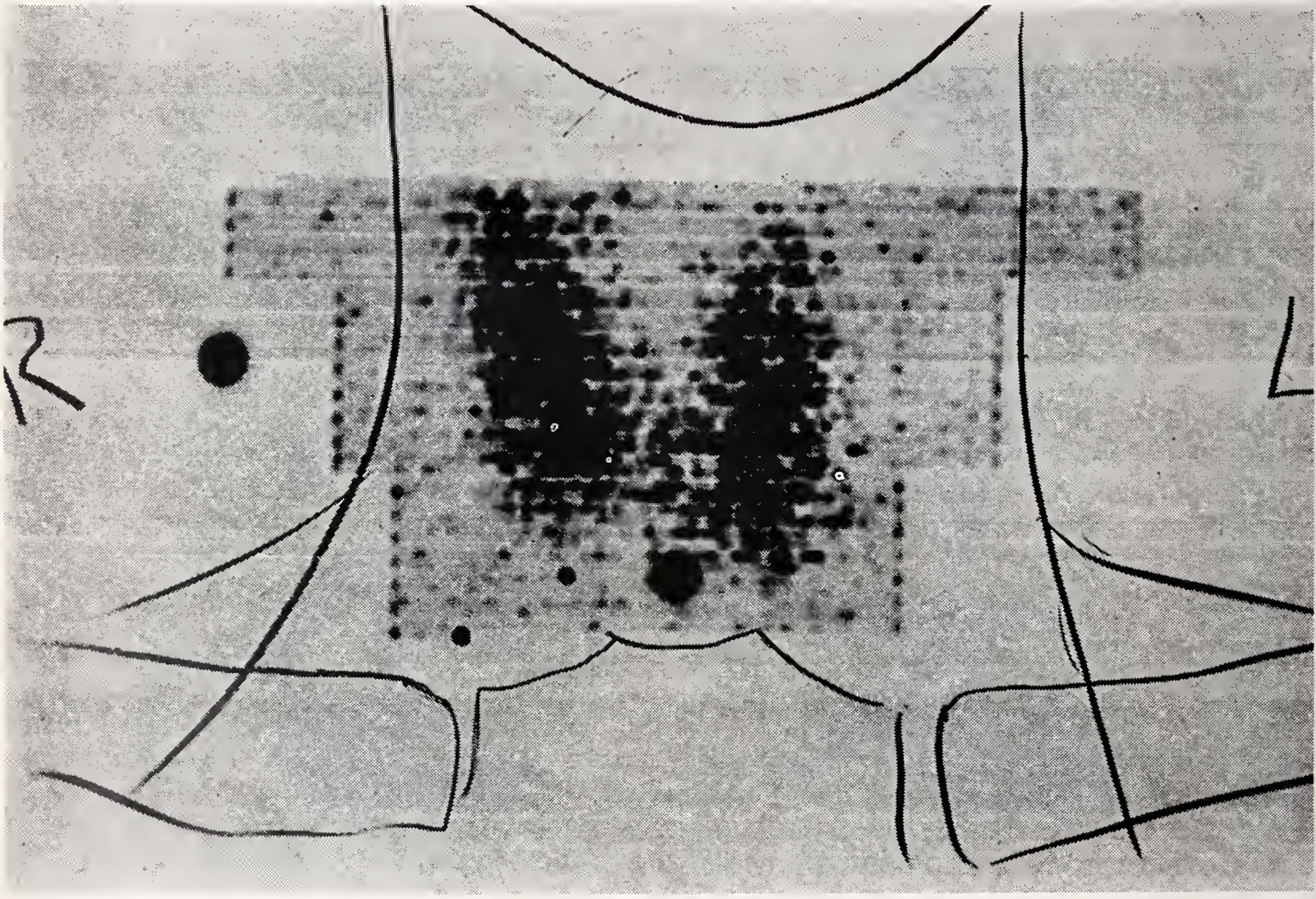
In my opinion scanning of the thyroid is a well established clinically useful procedure in evaluating the enlarged thyroid for possible surgery.

SPLEEN SCANS

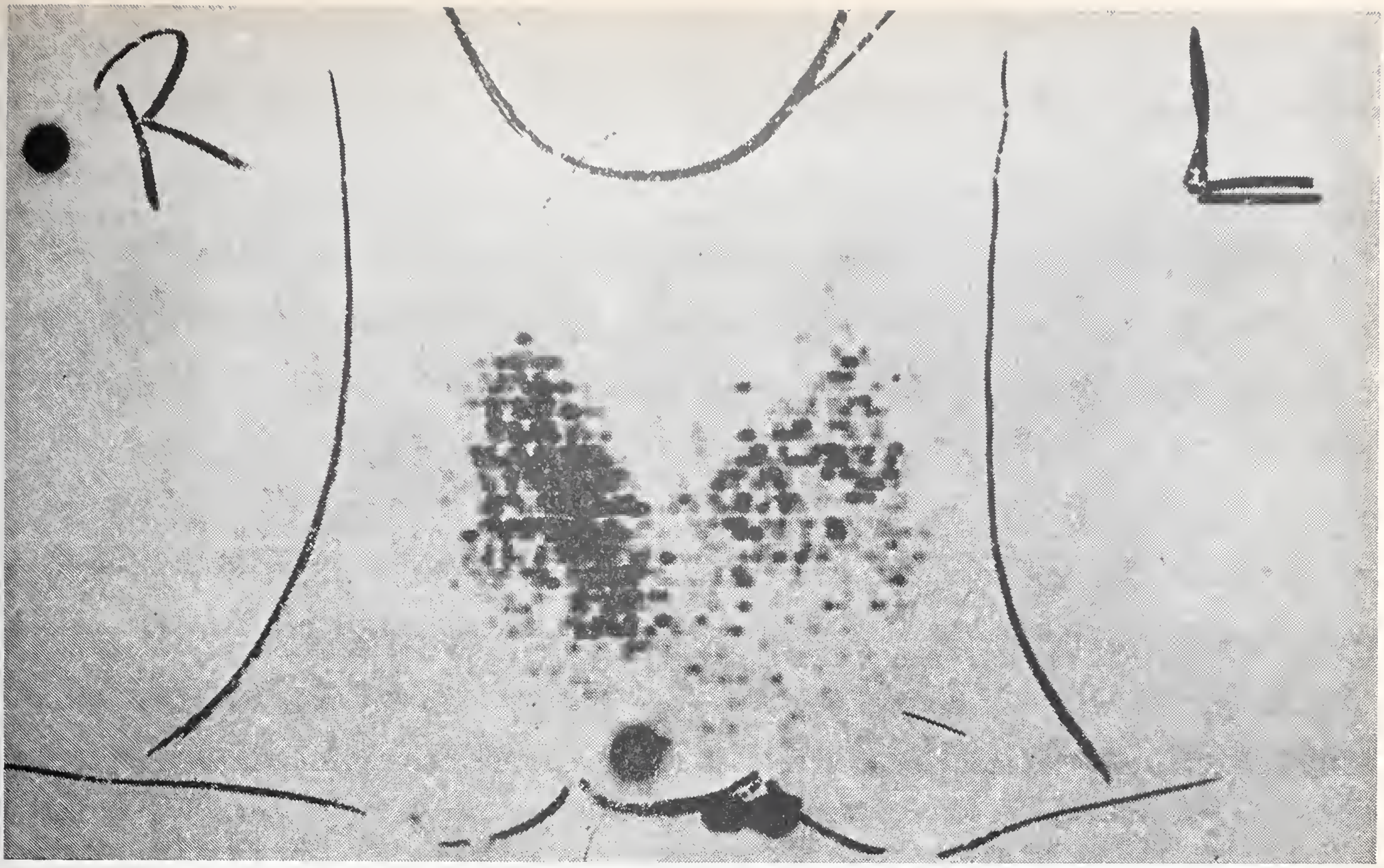
Of limited usefulness is scanning the spleen for ectopic location, accessory spleen, and identification of a questionable mass.[2] This scan is performed by labelling red cells with Chromium (Cr^{51}), heating the cells to damage the cell membrane so that the red cells will be removed from circulation by the spleen, followed by external scanning.

BRAIN SCANNING

Many brain tumors selectively accumulate radioisotope labelled compounds allowing direct



Case No. 1



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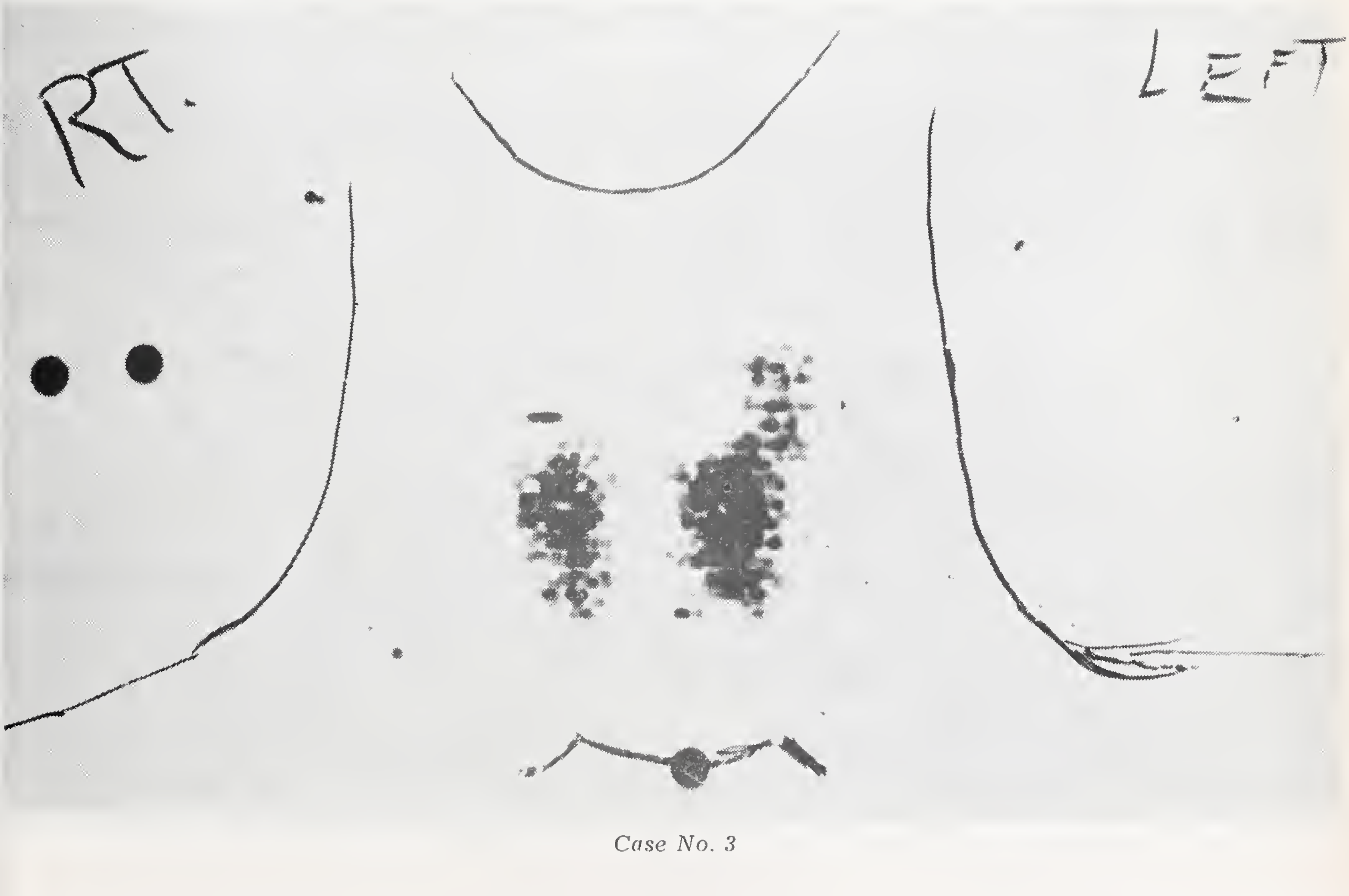


Case No. 3

visualization of the tumor on scintillation scanning.

The accuracy of the procedure in localizing brain tumors seems to be about 80% from the series so far reported. A very considerable body of literature utilizing various radioisotopes has appeared regarding the localization of brain tumors. Substances used in the past include P^{32}, K^{42}, As^{74}, As^{72}, Cu^{64}, and I^{131} labelled human serum albumen. However most of the interest at the present time centers on the various isotopes of Mercury tagged to the mercurial diuretics.

Brain tumor types found in positive scans include glioblastoma, meningioma, astrocytoma and metastatic lesions. Brain scanning with the isotopes entails very little risk or discomfort to the patient and is therefore a useful screening procedure. Other methods of brain tumor diagnosis ordinarily depend upon displacement of the cerebral arteries in cerebral arteriograms, the presence of tumor "stain" in arteriograms or the displacement of the air filled ventricles and subarachnoid spaces by the space occupying lesion.

It is of course evident that brain scanning does not replace competent neurological examination and standard tumor diagnosis techniques but rather extends the diagnostic techniques available. If a positive scan is obtained the other radiological studies may not be required. False negatives do occur in the event the tumor does not concentrate the radioisotope sufficiently above background radiation to detect. At Providence Hospital we have so far had one false negative brain scan in a woman later proven to have a brain tumor. This tumor was suspected on arteriography and proven at craniotomy.

Our technique utilizes radioactive mercury (Hg^{203}) labelled Neohydrin. Preferably a "loading" dose of mercurial diuretic is given to the patient 24 hours prior to the radioactive material to reduce the radiation dose to the kidneys. Approximately 700 microcuries of Hg^{203} Neohydrin is given intravenously and the scan done four hours later. An anteroposterior and lateral scan are done and the photographic scans are superimposed on radiographs of the skull in identical positions.

Illustrative Case No. 4

D.T. was a 40 white woman who had previously had a radical mastectomy for carcinoma of the breast. Brain metastasis was suspected from her clinical findings. The Hg^{203} Neohydrin scan shows a large, apparently solitary right posterior parietal metastasis. The patient expired soon after the scan.

HEART SCANNING

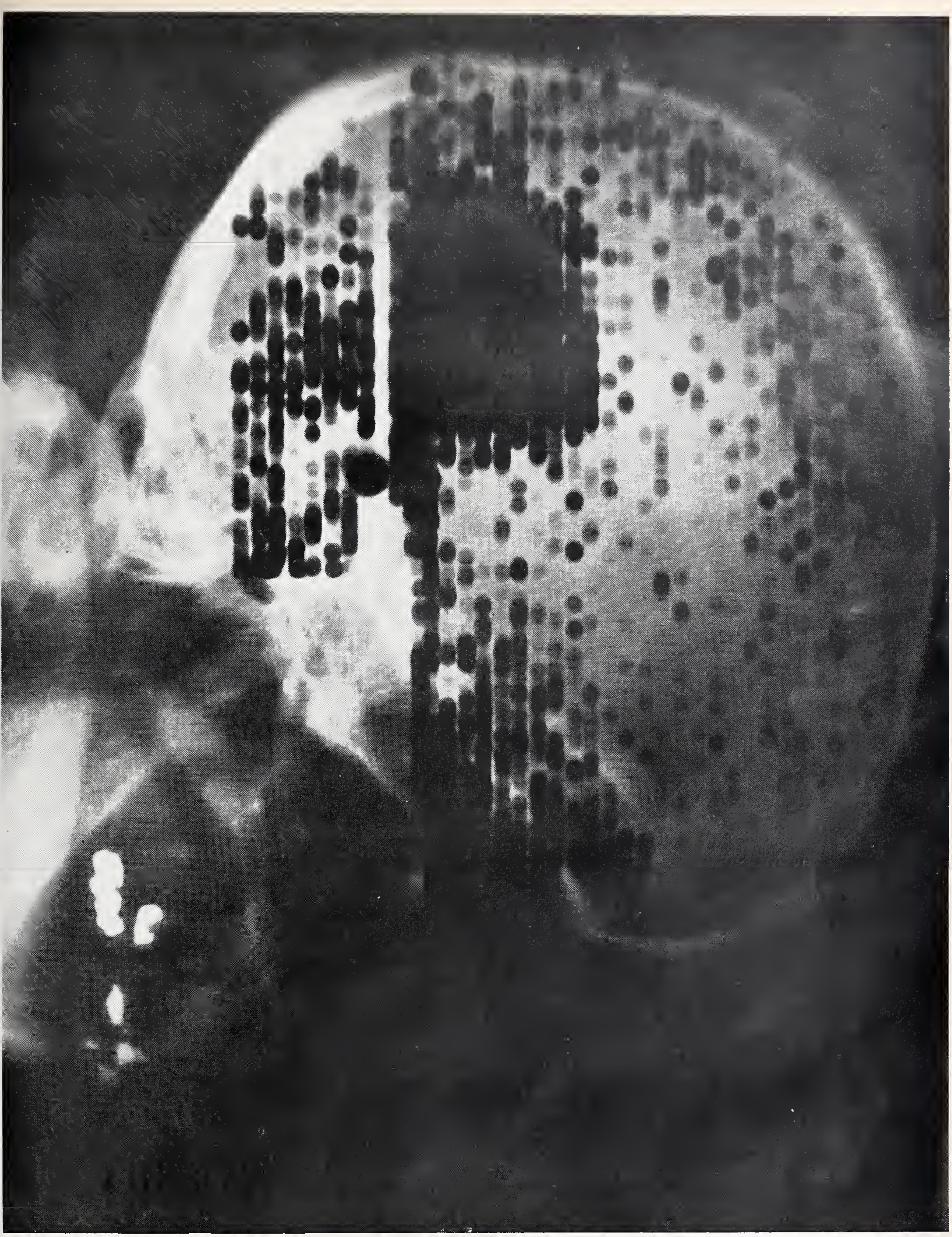
This is a very useful radioisotope scan which at present has only one proven indication — the differentiation of pericardial effusion from gross cardiac enlargement. I^{131} labelled human serum albumin is given intravenously and the heart "blood pool" is scanned with the heart chambers containing the radioactive material. This is analogous to a conventional stomach examination in which the stomach is filled with barium and films taken. In this procedure the heart chambers show uniformly black as a result of the radioactive serum albumin. The heart walls and effusion then show as the remaining peripheral portion of the heart shadow on the chest film taken in the same position. In the future it may be possible to demonstrate directly myocardial infraction by concentration of isotope in the infarcted tissue.[10]

LIVER SCANNING

Liver scanning is done with either gold (Au^{198}) or rose bengal labelled with I^{131}. The principal uses for this procedure include the detection of mass lesions within the liver. Metastases, cysts, abscesses and primary neoplasms can be studied.[8,11] There are definite limits of resolution of small mass lesions within the liver so that a positive scan is valuable whereas a negative scan does not exclude small metastases. Cirrhosis can also be suspected or confirmed in some instances on the liver scan; however this is not a particularly useful application.

RENAL SCANS

This is a procedure which may replace the radioisotope renogram in study and screening for renal vascular lesions in the study of hypertension.[6] At present it seems to be of definite value in patients with a nonfunctioning kidney on intravenous urogram, in hypertensive patients with suspected renal artery disease, in patients with apparent mass lesions on urograms and in the iodine sensitive patient.[5] The procedure utilizes Hg^{203} labelled Neohydrin. Brooks et al state "The use of Neohydrin Hg-203 is a good technique for detecting functioning renal tissue that is not apparent on excretory urograms." This would suggest its value in locating pelvic kidneys and other ectopic renal tissue. The renal scan is apparently quite accurate in the small series so

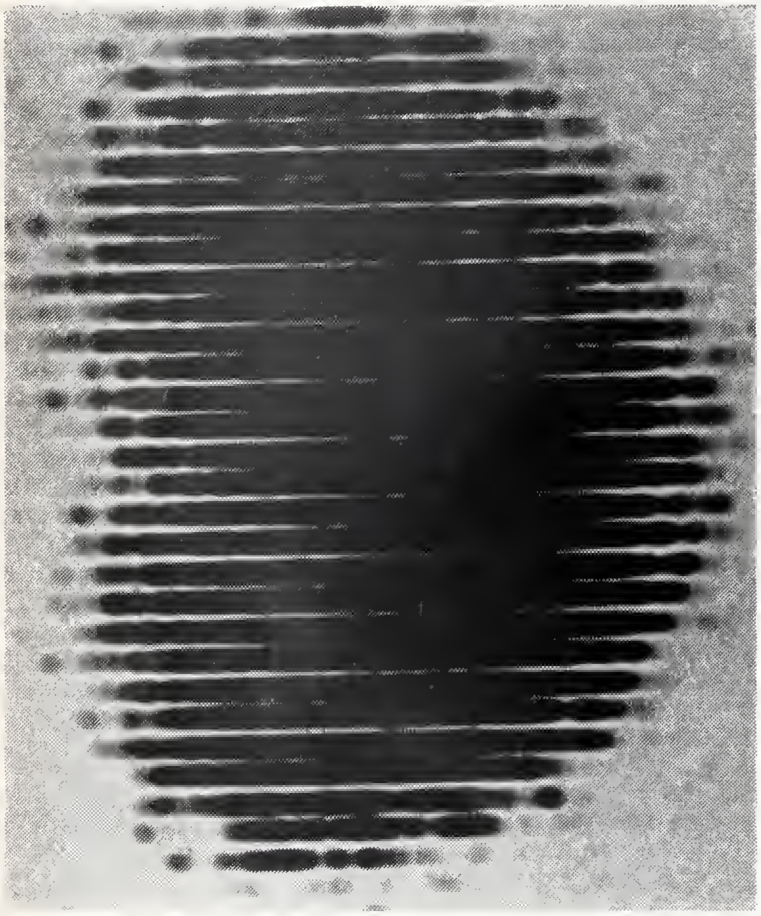


Case No. 4

far reported in revealing ischemic areas of the kidneys. The exact value of the radioisotope renogram has not as yet been determined but the above is the consensus at present.

Illustrative Case No. 5

C. M. was a 50-year-old man who had a right nephrectomy for stone many years prior to the scan. No urinary tract symptom or hypertension was present, the scan being done incidental to a brain scan. The scan shows a normal but hypertrophied left kidney.



Case No. 5

MISCELLANEOUS

Interesting preliminary work is being done on scanning the pancreas with Selenium (Se^{75}) labelled methionine. It is hoped that some method of scanning the pancreas will prove successful since radiographic demonstration of the pancreas is possible only indirectly. As yet this is experimental. Calcium and strontium are being used experimentally in attempts to demonstrate bone metastases and bone union of fractures.[12] Mercury (Hg^{203}) scans have shown the area of myocardial infarction in dogs following ligation of the coronary artery to the area. Lung scans following ligation of pulmonary arteries in dogs show the avascular lung; this type of study may eventually prove of value in the clinical demonstration of pulmonary infarction and vascular malformations.

SUMMARY

Radioisotope organ scanning is of proven value clinically in the study of the thyroid, suspected brain tumors, the kidneys, the heart for pericardial effusion and the liver for mass lesions. In general radioisotope scans do not replace other studies but rather extend the diagnostic range and accuracy of clinical evaluation of the organ in question. Scanning of other organs will become of clinical value as appropriate labelled substances are developed.

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Editorial Page . . .

CONGENITAL DEFECTS CLINIC

In mid January a Congenital Defects Clinic was held for the first time in Alaska under the joint sponsorship of the Anchorage Chapter of the National Foundation, the Alaska Department of Health, and the Alaska Crippled Children's Association. Alaska Department of Health and National Foundation Funds provided for expenses of bringing to Anchorage from the University of Washington an outstanding pediatrician, Dr. William Robertson, and a research geneticist, Dr. Fred Hecht, both of whom had had extensive previous experience in the field of congenital malformations. Alaska Department of Health funds aided in the transportation of patients to the clinics. The Alaska Crippled Children's Association provided the staffing and facilities for the clinical sessions.

In the course of two days approximately fifty patients—primarily babies and children with proven or suspected inherited chromosomal, metabolic, and other defects—were presented by private, Native Health Service, and military physicians. Although, at this initial clinic the emphasis was largely pediatric, it was evident that such clinics could be of benefit to internists, general practitioners, obstetricians, and other specialists as well.

Because of the nature of their problems, no patients were cured at this clinic. However, diagnosis was confirmed in some cases; blood specimens and buccal smears were collected on others and sent to the genetics laboratories in Seattle for further diagnosis; genetic counseling was offered to some families and other parents were reassured that their children probably did not have recognizable congenital defects. Local physicians were brought up to date on the latest diagnostic tools—and were introduced to newly recognized syndromes. The visiting specialists, on the other hand were introduced to at least one congenital sex-linked bone and joint dysplasia, occurring in Alaskan Eskimos of the lower Kuskokwim region, that to their knowledge had never previously been reported.

Of prime importance, none of the cases seen were advised to travel outside of Alaska for further diagnostic studies either at the regional National Foundation sponsored Congenital Defects Clinic at the Univeristy of Washington or elsewhere. The expenses of such travel is known to have been saved by several families who would have been forced to consider trips for evaluation were a clinic of this nature not available in Alaska.

Efforts of this nature by the voluntary health organizations to provide the services of diagnosis, counseling and physician education on a local level should be encouraged by all Alaskan physicians. More publicity and wider physician participation is warranted should the National Foundation choose to make the Congenital Defects Clinic an annual or biennial occurrence in Alaska.

PUBLIC RELATIONS

Lu Ausman, a medically oriented and prominent journalist and public relations specialist, has been retained by the ASMA during the current year. Funds for this position were budgeted by the Council at its meeting following the ASMA Convention in May, 1963. Following is a letter from Mrs. Ausman to each member, in which she introduces herself, and explains how she will be best able to function in her new capacity:

> Doctor, please **do** something!
>
> Often when the doctor hears that plea he knows that at that moment in the mind of the patient he stands second only to God.
>
> While people hope for but do not exactly expect major miracles, they often do not know of the many minor miracles their doctor performs during the course of his daily work.
>
> It is my job to tell — and to explain.
>
> When doctors ask for "better medical practice" legislation, what do they mean? How many hours of their time do they give to counseling with local governments or public health agencies to study and resolve problems pertaining to the general welfare? How do doctors help in the rehabilitation of a patient who has been injured, or mentally or physically ill? How does the doctor participate in worthwhile community projects? What is his opinion on controversial subjects?
>
> The doctors' answers to these and countless other questions command respect from the general public even in cases where the individual believes the opposite. He becomes convinced that his doctor takes a genuine and personal interest in his patients and in his community, as indeed he does.
>
> So, please doctor, supply me with the information I need to translate you to your public. When anything of possible medical interest in your community occurs, or when your name is mentioned in the local paper, please send me a tear sheet (the entire page). I shall take it from there. Your ideas and suggestions are also welcomed. Address me in care of Robert B. Wilkins, M.D., ASMA Secretary-Treasurer, 718 "K" Street, Anchorage, Alaska.

TENTATIVE PROGRAM OF THE NINETEENTH ANNUAL AND FIRST INTERNATIONAL CONVENTION OF THE ALASKA STATE MEDICAL ASSOCIATION

ELKS CLUB, KETCHIKAN, ALASKA

May 26 - 30, 1964

OFFICERS

President	Ralph W. Carr, Ketchikan
Past-President	William J. Mills, Jr., Anchorage
President-Elect	Donald E. Tatum, Fairbanks
Vice-President	Robert D. Whaley, Anchorage
Secretary-Treasurer	Robert B. Wilkins, Anchorage

COUNCILORS

Southeastern	Edward D. Spencer, Sitka
Southcentral	J. Bruce Keers, Kodiak
Anchorage Area	A. S. Walkowski, Anchorage
Northern	James A. Lundquist, Fairbanks

TUESDAY, May 26th

Organization and Informal Business Meeting

8:00 P.M.—Meeting of the Council

WEDNESDAY, May 27th

8:00 A.M.—Coffee and rolls at Elks

9:00 A.M.—Registration of Doctors and Visiting Exhibits

10:20 A.M.—Opening of Convention with Invocation by Rev. M. B. Dunham

10:30 A.M.—MR. WARREN GRIFFIN "The Medical Disaster Planning and Civil Defense Emergency Hospital Programs in Alaska." To be followed by answering of questions.

11:00 A.M.—FEDERAL-STATE PANEL: CHAIRMAN DR. LEVI M. BROWNING, and PANELISTS DRS. GRACE E. FIELD, HOMER F. RAY, JR., GEORGE M. WAGNON, H. R. WHERRITT, and EDWIN O. WICKS "The Future of Medical Programs in Alaska."

12:00 —Lunch at Elks

1:30 P.M.—R. J. WEDGEWOOD, M.D. "The Diagnosis and Treatment of Rheumatoid Arthritis in Children"

2:00 P.M.—WILLIAM RANDOLPH LOVELACE, II, M.D., "Congenital Lesions of the Neck and Surgical Treatment"

2:30 P.M.—GEORGE T. PACK, M.D. "Heredity of Human Cancer" - one-hour talk

THURSDAY, May 28th

8:00 P.M.—Coffee and Rolls at Elks by Emblem Club

9:00 A.M.—RICHARD KOCH, M.D. "Developmental Problems in Early Childhood"

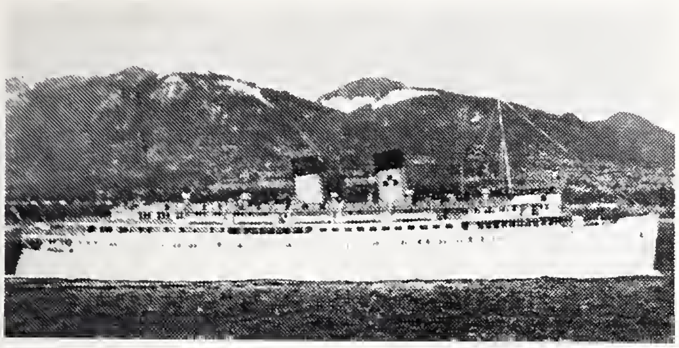
9:30 A.M.—WILLIAM RANDOLPH LOVELACE, II, M.D. "The Long Range Effect of the Aerospace Medical Program on Clinical Medicine"

DR. WILLIAM RANDOLPH LOVELACE II, M.D.
President of the Air Force Association

10:00 A.M.—Coffee Time

10:30 A.M.—JOEL W. BAKER, M.D., THOMAS CARLILE, M.D., and LEWIS CORWIN ROBBINS, M.D.
- Mammography Panel

11:30 A.M.—Lunch at Elks



S.S. PRINCESS PATRICIA

1:00 P.M.—Arrival at Heckman Wharf (3 blocks away from Elks Club) of Convention Cruise Ship SS Princess Patricia and 150 doctor couples of General Practice Section of British Columbia Medical Association. Metlakatla High Band with drill marching, while ship ties up.

The ladies and any doctors who wish to may go on a charter bus tour of Ketchikan and outlying totem parks. Any wishing to fly to view Eddystone Rock (named by Vancouver in 1792) or The Punchbowl of Rudyard Bay may charter an 8-passenger Alaska Coastal-Ellis plane.

1:30 P.M.—JOSEPH CLUFF, M.D.
"Recent Advances in Neurosurgery"

2:00 P.M.—ALBERT B. BROWN, M.D.
"Prolonged Labor"

2:30 P.M.—THOMAS CARLILE, M.D.
"The Radiographic Diagnosis of Polyps and Neoplastic Lesions of the Colon"

3:00 P.M.—LEWIS L. ROBBINS, M.D.
"Emotional Reactions to Physical Illness"

3:30 P.M.—JOEL W. BAKER, M.D.
"The Abdominal Exploration"

6:30 P.M.—Accordianist June Kisiel (14 years in showbusiness in Scotland) in Elks Cocktail Lounge

7:30 P.M.—Alaska Heart Association Banquet - Grace E. Field, M.D., President
Address: "Can Heart Attacks be Prevented?" by DR. JEREMIAH STAMLER

10:00 P.M.—Get-Acquainted Dance, Orchestra - The Metlakatla Harmoneers

FRIDAY, May 29th

8:00 A.M.—Coffee and rolls at Elks

9:00 A.M.—GEORGE T. PACK, M.D.
"The Present Day Management of Cancer of the Stomach"

9:30 A.M.—A. McGEHEE HARVEY, M.D.
"Auto-Immune Disease"

10:00 A.M.—Coffee Time

10:30 A.M.—JOEL W. BAKER, M.D.
"Tailoring the Operation to the Patient with Duodenal Ulcer" - 27 minute movie with time for questions at completion of movie.

12:00 Alaska Heart Association Luncheon and Business Meeting

1:30 P.M.—WILLIAM L. ROHNER, M.D.
"Radiographic Diagnosis in Acute Abdominal Trauma"

2:00 P.M.—LEWIS L. ROBBINS, M.D.
"Doctor-Patient Relationship"

2:30 P.M.—A. McGEHEE HARVEY, M.D.
40 Minute Movie of Cineangiography Illustrating Failure, Heart Disease, and Selective Visualization of the Coronary Arteries

3:30 P.M.—BLAIR J. HENNINGSGAARD, M.D.
"Your AMA"

6:30 P.M.—Cocktail Hour, Elks, sponsored by ALASKA STATE MEDICAL ASSOCIATION

7:30 P.M.—ASMA Banquet served by Emblem Club - Dr. Ralph W. Carr, M.D., Presiding - Medical Travelogue Associated with Special Research Unit in Calcutta, India, with Study of Cholera and Other Diseases, by A. M. HARVEY, M.D.

10:00 P.M.—Thlingit Indian Costume Dance by Saxman Native Villagers, and Comments by The Honorable Joe Williams, Mayor.

SATURDAY, May 30th

8:00 A.M.—Coffee and rolls at Elks

9:00 A.M.—Newly - Elected ASMA President Donald E. Tatum, M.D., Presiding.
JOEL W. BAKER, M.D.
"The More Complete Surgical Decompression of Intestinal Obstruction with Special Reference to a Method."
30-minute talk, including 5-minute section of a movie.

10:00 A.M.—Coffee Time

10:30 A.M.—JEREMIAH STAMLER, M.D.
"Rheumatic Fever Prevention"

11:00 A.M.—HOWARD HOPPS, M.D., Pathologist, Armed Forces Institute of Pathology.
"Biopsy Techniques"

Hotel reservations may be made through Dr. A. N. Wilson, Box 2577, Ketchikan.

Exhibitors desiring booths may arrange through Dr. Ervin O. Winton, 2433 First Avenue, Ketchikan.

The Emblem Club will serve coffee and rolls at the Elks each morning at breakfast time, and also serve buffet luncheons there.

Registration fee Wednesday, May 27th, will be $5.00. There will be no registration fee for our Canadian guests May 28th.

The cost per plate at each banquet will be $5.00.

SPONSORS OF PROGRAM SPEAKERS

Alaska Department of Health and Welfare
Alaska Heart Association
American Academy of General Practice
Astra Pharmaceutical Products, Inc.
American Cancer Society - Alaska Division
Ayerst Laboratories
Eli Lilly and Company
The Mason Clinic
Merck Sharp & Dohme
The National Foundation—"March of Dimes"
E. R. Squibb & Sons
Tacoma Medical Center
United States Public Health Service
General Practitioner-Psychiatry Education Project
University of Utah College of Medicine
Wyeth, Fund for Postgraduate Medical Education

PROGRAM SPEAKERS

JOEL W. BAKER, M.D., Chief, General Surgery and Gynecology, The Mason Clinic, 1118 9th Ave., Seattle 1, Wash.

DR. ALBERT B. BROWN, OB-Gyn. Specialist, Saskatchewan, Canada

LEVI M. BROWNING, M.D., Commissioner of Health, Alaska Department of Health and Welfare, Juneau, Alaska

THOMAS CARLILE, M.D., Chief, Department of Radiology, The Mason Clinic, 1118 9th Ave., Seattle 1, Wash.

JOSEPH CLUFF, M.D., Neurosurgeon, Vancouver, British Columbia, Canada

GRACE E. FIELD, M.D., Clinical Director, Veterans Administration, Regional Office, Goldstein Bldg., Box 2626, Juneau, Alaska

MR. WARREN GRIFFIN, Public Health Advisor for Health Mobilization, 327 Eagle St., Anchorage, Alaska

A. McGEHEE HARVEY, M.D., Director, Department of Medicine, The Johns Hopkins University School of Medicine, Baltimore 5, Md.

BLAIR J. HENNINGSGAARD, M.D., The Fowler Clinic, 486 Twelfth Street, Astoria, Oregon

HOWARD HOPPS, M.D., Pathologist, Armed Forces Institute of Pathology, Washington, D.C.

RICHARD KOCH, M.D., Associate Professor of Pediatrics, University of Southern California, School of Medicine, 4616 Sunset Blvd., Los Angeles 27, California

WILLIAM RANDOLPH LOVELACE, II, M.D., President, The Lovelace Foundation, 4800 Gibson Blvd., S.E., Albuquerque, New Mexico

GEORGE T. PACK, M.D., Pack Medical Group, 139 East Thirty-Sixth Street, New York 16, New York

HOMER RAY, M.D., Psychiatrist, Mental Health Program, Dept. of Health and Welfare, Juneau, Alaska

LEWIS CORWIN ROBBINS, M.D., Division of Chronic Diseases, U.S. Public Health Service, Washington 25, D.C.

LEWIS L. ROBBINS, M.D., Medical Director, Hillside (Psychiatric) Hospital, 75-59 263rd St., Glenn Oaks, N.Y.

JEREMIAH STAMLER, M.D., Director, Division of Adult Health and Aging, Heart Disease Control Program, Chicago Board of Health; Assistant Professor Dept. of Medicine, Northwestern University Medical School; Executive Director, Chicago Health Research Foundation, 54 W. Hubbard, Chicago, Illinois

WILLIAM L. ROHNER, M.D., Radiologist, The Tacoma Medical Center, 1206 South 11th, Bldg. 15, Tacoma, Washington

GEORGE H. WAGNON, M.D., Medical Director, AANHAD, Medical Officer in Charge, Director, SE Alaska Service Unit, Mt. Edgecumbe, Alaska

R. J. WEDGEWOOD, M.D., Professor and Chairman, Dept. of Pediatrics, University of Washington, School of Medicine, Seattle, Washington

HOLMAN R. WHERRITT, M.D., Medical Director, Alaska Native Health Area Director, Box 7-741, Anchorage, Alaska

EDWIN O. WICKS, M.D., Dr. P.H., Director, Dept. of Health and Welfare, Alaska Office Building, Juneau, Alaska

President's Page . . .

RALPH W. CARR, M.D.
President, Alaska State Medical Association

I should like to devote the President's Page of this issue of ALASKA MEDICINE to the subject of malpractice insurance. (Malpractice, since it is now a vocational hazard of the practice of medicine, is preferably referred to as professional liability.) I have been in correspondence with a friend of mine, Dr. Joseph F. Sadusk of George Washington University Hospital in Washington, D.C. who has been studying malpractice on both coasts for 13 or 14 years. Dr. Sadusk has been a member of the Committee on Medical Legal Problems of the A.M.A., and beginning last year has been serving as chairman of the committee. He has written me a three page letter on this subject in which he says in part:

> "I am sorry to hear about your malpractice problems for physicians in Alaska, but on the other hand, I am very delighted to know that your Association wants to take active steps to control the situation. I have known for some time that the malpractice situation in Alaska was bad, through knowing about your relatively high premium rates in that state for medical malpractice insurance coverage. As you know, premium rates for insurance generally reflect well the hazard in a given area. . . . . . I should believe that the proper way to handle the problem in your state, based upon your information that at least 50% of Alaska doctors are in Anchorage, is to set up a group medical malpractice insurance program, and then to use such a program for the institution of a good preventive program against malpractice. This depends primarily upon acquainting physicians with the problems of malpractice, how to avoid malpractice claims, and what to do about claims and the handling of such claims if and when malpractice is committed.
>
> "I wonder if the way to handle your problem is to have an all morning session on the problems of medical malpractice at your next Alaska State Medical Association Annual Meeting, and invite several authorities in the field to come up and discuss the matter in meeting with your membership. At this time you might also arrive upon a decision to have a group malpractice program and I am sure that we can give you some help in applying to companies who have similar programs elsewhere in the United States and who might be willing to set up a program for you. It has certainly been my experience during the 13 or 14 years in which I have been working in the field of malpractice that the first requisite is to set up a group program, and to do away with individual malpractice insurance coverage.
>
> "I might also tell you that our Committee on Medicolegal Problems is seriously considering the setting up of meetings on the subject of medicolegal education and malpractice every other year. It would be our plan to bring in one or several individuals from each State Medical Association, along with hospital administration personnel who have a like interest in the field, to discuss such matters in an intensive fashion. If we decide to do this, there will be appropriate notice made and you will hear about it."

I have been in correspondence also with several insurance carriers including John L. Krause and Associates of Glenview, Ill., which offers group malpractice insurance to members of the International College of Surgeons. They have presented a proposal based upon having at least 50 members of the State Association as participants. The following exerpt from this correspondence with John L. Krause and Associates states this possible rate schedule:

> "As you know, doctors are now divided into four categories, and the rate fluctuates according to the type of practice. Category I doctors are those that perform no surgery; Category II doctors are those that perform minor surgery, or assist in major surgery on their own patients; Category III doctors are Ophthalmologists and Proctologists, or General Practitioners who perform major surgery on their own patients; Category IV doctors are major surgeons and Anesthesiologists. The rates suggested by the National Bureau for the various categories are as follows:

Limits of Liability In Thousands	**$5/15**	**$25/75**	**$50/150**	**$100/300**
Total Annual Premium:				
Category I	$59.00	$100.89	$111.51	$121.54
Category II	$74.00	$126.54	$139.86	$152.44
Category III	$142.00	$242.82	$268.38	$292.52
Category IV	$252.00	$362.52	$400.68	$436.72

> Limits of Liability up to $200/600,000 may be obtained for approximately $50.00 per year more than the $100/300,000 rate. The rates offered your Society will be the present existing rates shown above, less 10%."

By the May meetings I should have other sample proposals as well to present for consideration. In the meanwhile, Dr. Sadusk has suggested that ALASKA MEDICINE reprint his article from CALIFORNIA MEDICINE, Vol. 88, No. 1, January 1958, entitled "Analysis of Your Professional Liability Insurance Policy."

ANALYSIS OF YOUR PROFESSIONAL LIABILITY INSURANCE POLICY

JOSEPH F. SADUSK, Jr., M.D., Oakland
*HOWARD HASSARD, LL.B., and ROLAND WATERSON, San Francisco**

Reprinted from California Medicine, Vol. 88, No. 1, January, 1958

The problems of adequate professional liability insurance coverage have become increasingly obvious to physicians with the rapid and progressive increase in premiums for such insurance since World War II. These problems, together with the growing complexity of the field and the increasing size of claims, settlements and judgments, make it mandatory for the physician to know whether or not he is adequately protected. Many are not.

Every physician should read his professional liability policy carefully to determine the extent of his coverage. The purpose of this communication is to guide him in an analysis of his contract and of other important aspects of his insurance protection.

The physician's analysis should, of course, be supplemented by the advice of an attorney who is thoroughly familiar with current malpractice trends in the state in which the physician practices. Professional liability insurance coverage is a very highly specialized branch of the industry; relatively few otherwise qualified attorneys and insurance men realize the implications of policy provisions, insuring agreements, applications, exclusions, the need for long term coverage by a stable carrier, expert claims service and other factors. Futhermore, professional liability risks are not uniform and static; the problems vary from physician to physician, from locality to locality and from time to time. Some brokers and insurance company representatives are properly qualified and currently informed, but the fact that many are not is evidenced by the faulty contracts sold to many physicians. Many state medical associations and some county societies retain legal counsel who are well qualified to provide the highly specialized advisory service required by the purchaser of professional liability insurance.

THE GENERAL PROBLEM

The increasing problems in professional liability coverage are nationwide. In some states, insurance carriers have cancelled or drastically modified their coverages because of an increasing hazard in which the ratio of incurred losses to premiums (loss-ratio) continues to soar faster than the rapid increase in premiums.

As an example of the mounting hazard, statistics for a group program in Northern California show that during the period 1946 through 1951, one of every twelve physicians had a malpractice claim of some type levied against him each year. One of every fifty-two physicians in the program has an actual malpractice suit filed against him each year. One of every fourteen physicians had a complaint presented by a patient which required investigation by the insurance carrier.

• The most important lessons for the physician to learn in regard to his professional liability insurance coverage are the following:

1. The physician should carefully read his professional liability policy and should secure the educated aid of his attorney and his insurance broker, if they are conversant with this field.

2. He should particularly read the definition of coverage and carefully survey the exclusion clauses which may deny him coverage under certain circumstances.

3. If the physician is in partnership or in a group, he should be certain that he has contingent partnership coverage.

4. The physician should accept coverage only from an insurance carrier of sufficient size and stability that he can be sure his coverage will be guaranteed for "latent liability" claims as the years go along — certainly for his lifetime.

5. The insurance carrier offering the professional liability policy should be prepared to offer coverages up to at least $100,000/$300,000.

6. The physician should be assured that the insurance carrier has claims-handling personnel and legal counsel who are experienced and expert in the professional liability field and who are locally available for service.

7. The physician is best protected by a local or state group program, next best by a national group program, and last, by individual coverage.

8. The physician should look with suspicion on a cancellation clause in which his policy may be summarily cancelled on brief notice.

9. The physician should not buy professional liability insurance on the basis of price alone; adequacy of coverage and service and a good insurance company for his protection should be the deciding factors.

Even more disturbing is the growing dissatisfaction of insurance carriers with the field of professional liability, with the result that more and more carriers are discontinuing insurance of this type. Indeed, some insurance carriers, realizing that this is a losing field, have offered professional liability insurance to a physician only if he permits the carrier to sell him other types of insurance on which a profit can generally be made. This is commonly known as the "package deal."

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*Member, Committee on Medical-Legal Problems, American Medical Association; formerly Chairman, Medical Review and Advisory Board, California Medical Association (Sadusk); Legal Counsel, California Medical Association (Hassard); Executive Secretary, Medical Review and Advisory Board, California Medical Association (Waterson).

There are four factors which make the insurance carrier dissatisfied with the field of professional liability:

1. The problem of latent liability.

2. The progressive increase in losses in such insurance due to inflation and the increasingly critical attitude of public, juries and judges toward medicine.

3. The relatively small volume of sales of this type of insurance.

4. The growing dissatisfaction of physicians with the progressive increase in premiums by means of which the insurance carrier hopes to offset staggering losses.

The problem of the latency of medical practice claims is doubtless the most distressing of these factors to the insurance company. This "latent liability factor" may be defined as the relatively long lapse of time between the alleged act of malpractice and the filing of a claim or suit. With automobile and other types of liability insurance, the carrier generally knows at the end of each policy year, or shortly thereafter, the entire extent of its liability exposure. With medical malpractice, on the other hand, claims for alleged malpractice may not become known until many years after the incident which is cited as a basis for the claim. This problem varies from state to state, depending upon the statute of limitations for filing of a suit. In some states, the statute is strictly applied by the courts. In these states, the patient may file a suit only during the period defined by the statute, which begins to run on the date upon which the last treatment was given by the physician or when the patient reaches majority or regains mental competency. In California, the statute is interpreted by the courts as providing that a patient may file a suit or claim against a physician one year **after the patient has acquired knowledge** of a right of action. This means that the patient has practically his entire life or the physician's lifetime in which to file a suit. For instance, if a surgeon inadvertently leaves a clamp in an abdomen during an operation and the patient is told forty years later, when a gastro-intestinal series is made, that such a clamp is present, the patient then has one year in which to file a suit. In the case of minors, the statute of limitations begins to run only after the child reaches his majority — at age 21. Thus the physician who treats an infant today may be sued for the results of that treatment more than 21 years hence. Because of these "latent liability" factors of professional liability insurance, it is impossible for insurance carriers promptly to compute losses with any accuracy for a given year. The insurance policy for the year in which the incident occurs is the policy which covers the physician for his acts and ommissions of that year, regardless of the year in which the suit is filed. This is a most important point for physicians to know.

The latent liability factor, when combined with the constant inflationary spiral, creates another major problem for the professional liability insurer. Premiums collected today are based on today's economy — upon current costs of defending cases and upon the size of judgments being awarded by today's juries. But what will the costs and judgments be, say twenty years from today? If by that time inflation of today's economy is 100 per cent, then the premium collected today is only half enough to pay the costs and indemnities of latent suits filed in 1977 for an act of alleged malpractice in 1957.

Over the entire country it is clearly evident that the incidence of malpractice suits per hundred physicians insured has increased considerably since World War II, and that inflation has produced both an increase in the size of judgments and an increase in the cost of defense. These factors necessarily lead to an increase in the premium.

The physician should also realize that the interest of insurance carriers in medical malpractice insurance is not great because of the relatively small number of potential sales for medical malpractice insurance as compared to other types of liability coverage. The average insurance carrier looks upon the selling of malpractice insurance as a "courtesy" or "accommodation" rather than a profitable enterprise. When the problem becomes too great, the carrier deserts the professional liability field.

THE INSURANCE CARRIER

The selection of an insurance carrier for professional liability coverage is of paramount importance because of the latency of malpractice claims, i.e., a claim may be entered or a suit be filed against a physician many years after the year to which the policy and premium applies.

It is therefore most important that the insurance carrier be selected on the basis of its past, present and predictable future stability. There should be every reason to believe the company will remain in business and will remain stable for many years — at least for the duration of the physician's life. The carrier should be licensed under the insurance laws of the state in which the physician practices, or be permitted by such laws to write contracts as a surplus line insurer.

The size of the company should be substantial. One rule of thumb applied in one group program is that paid-in capital and unassigned surplus of the carrier should be at least ten times the aggregate annual gross premiums paid by all physicians in the group for malpractice insurance for the immediately preceding year, or a minimum of $5,000,000, whichever is greater. No precise rule can be stated — resources available to policyholders should be substantial.

The carrier should preferably be a company with its home office in the United States. If the carrier has its home office in a foreign country, there should be adequate reserves of the carrier **on deposit in the United States and applicable to payment of the physician's malpractice claim.** This is important since at some remote future date there may arise a conflict between the carrier and the physician as to the payment of a judgment. The physician will then be able to sue the company in his own state or in federal courts only if the carrier is in the United States or has applicable funds on deposit in the United States. If the carrier were a foreign company, with no money on deposit and specifically assigned to this purpose in the United States, the physician would be obliged to enter suit against the carrier in the courts of the foreign country. The laws of that country could apply.

Finally, an insurance carrier with previous experience in the malpractice field should be preferred over those with no previous experience. The reason for this will become obvious in later discussion.

It is profitless to discuss the pros and cons of the stock versus the mutual company, since the matter is one of individual preference. Further, the size, stability, efficiency, experience and service of companies are the important variable factors and should be the deciding ones.

There are two additional points to consider. There should be some evidence that the policy will be renewed each year and there should be sufficient volume of business for the insurance carrier in the area in which the physician practices for it to have experienced malpractice claims adjustors and defense counsel immediately available.

TYPE OF PROGRAM

A **local** (county or state medical society) **group** malpractice program has many advantages over the individual malpractice policy. Here are a few of the advantages:

1. Better Insurance Protection

Group negotiation can make possible a far better and safer insurance contract than is uniformly made available to individual physicians. For example, some group contracts have been drafted, not by the insurance company, but by the attorney for the group. In such groups the coverage is uniformly broad, exclusions are safe and well defined and policy provisions reflect the needs of the insured as well as the insurer. Such carefully "tailored" contracts make it unnecessary for the members of the group to concern themselves with every technical detail in the policy, whereas, to be safe, physicians buying individual contracts must have them analyzed in detail.

2. No Underwriting Discrimination

Some insurance carriers discriminate against physicians who are known to be hazardous risks because of their field of work: (one carrier recently refused coverage to orthopedists, plastic surgeons and radiologists.) Who is to be excluded from medical malpractice insurance coverage — which may be tantamount to being excluded from medical practice — should be a determination of physicians rather than insurance underwriters. Such discrimination is prevented by group programs.

3. Control of Procedures by Physicians

At times and in certain areas, insurance companies have effectively prevented physicians from performing certain hazardous procedures through excluding insurance coverage of those procedures or by the device of surcharges so high that physicians could not afford to pay the premium and therefore discontinued doing the procedures. Under a group program such underwriting controls by insurance companies over what procedures a physician may perform are held within reasonable bounds.

4. Collection of Loss Data

Few, if any, insurance companies writing professional liability coverage on an individual basis keep separate and adequate malpractice loss data; none will divulge such information if they have it. Under a group program, loss data may be collected by the group and analyzed with the objectives of testing the reasonableness of premiums and, most important, establishing the underlying causes of claims and suits. Without knowledge of causes and sources of claims, there can be no effective prevention program.

5. Prevention (Safety) Programs

Based upon loss data that can be collected only under a group program, the group may set up an effective prevention — or safety — program, with a long term view to reducing the incidence of claims and lessening liability.

6. Better Defense of Suits

In addition to protection against financial loss, the professional liability carrier contracts to provide a highly specialized professional service: The defense of law suits that may be brought against the insured. The expertness of this service is of paramount importance to the physician when he becomes the target of a malpractice claim or suit. The volume of suits defended under a group program is usually great enough to provide the required experience for the defense attorney or group of attorneys retained by the group carrier. On the other hand, when physicians are separately insured under a number of carriers, their locally available attorneys seldom have enough malpractice trial work to become experts in the field. It has been learned that otherwise-brilliant attorneys who are without long experience in professional liability trial work are handicapped in the defense of a malpractice suit.

There is another reason many suits are better defended under a group program. In an increasing number of cases two or more physicians are named defendants in the same lawsuit. When each physician is individually insured by a different carrier, each has a different attorney, representing a different insurance company, to defend him. It is the duty of each of these attorneys to defend his individual client — and to protect the funds of his own insurance company. During the trial of an unwarranted suit this is sometimes accomplished by subtly pointing the finger of invented blame at another insurance company's defendant doctor. The "defense" of the case becomes a farce of shifting nonexistent blame; the jury is convinced that there is liability where actually there is none and the case is lost — by one or more of the separately insured doctors. Under a group program, however, where all defendant doctors have the same insurance, the total effort is to cooperate to defend the unwarranted **case.** The group carrier has incentive only to defend the **case,** not to get one doctor out by making another assume a liability that does not exist.

7. Better Claims Handling

Closely allied to defense is another vital service — claims handling. This involves investigation of each case, including all records and other pertinent and often highly technical medical information. Claims handling also includes negotiations with claimants and their attorneys, judgments as to whether to defend or settle cases, assistance in preparation for trial and many other matters that must be handled with great skill and understanding. It will readily be seen that years of training and experience with many professional liability claims are required to develop expert malpractice claims managers. Companies handling a small volume of professional liability cases cannot develop an able, specialized, malpractice claims handling team. Group coverage permits the development of skilled claims managers. This is of great importance to the insured physician, because poor claims handling turns minor incidents into major lawsuits that require weeks of the physician's time in preparation for trial and many days in court, not to mention financial risk and the inescapable emotional trauma. Physicians should remember that they buy **both** financial protection and a number of vital and highly specialized services when they buy malpractice insurance. The service is often more important than the financial protection.

8. Influence Over Claims Disposition

Under a proper group program, a committee of physicians representing the group assists in the investigation of the technical aspects of claims and can have considerable influence over which claims are to be paid by out-of-court settlement and which are to be defended. Without such a voice in the disposition of claims, decisions to settle or defend may be guided by insurance company expedience rather than in terms of the long range needs and objectives of the profession.

Summarizing this section, it becomes clear that neither knowledge nor control of its own malpractice problem are available to the profession except under properly designed group professional liability programs. Malpractice is a medical problem. Insurance companies can and do desert the field of malpractice, but the profession must continue to live with it. Better coverage, better claims handling and legal defense, better prevention programs, more equitable selection of risks and better control of the entire problem of professional liability are the advantages of group over individual insurance underwriting. The long range interests of the profession, rather than the immediate interests of the insurance carrier, are served by the group program.

STATE OR COUNTY VERSUS NATIONAL GROUPS

Malpractice insurance programs of the national specialty groups share some of the advantages of local group plans over individual underwriting, but there are also distinct disadvantages and dangers inherent in this approach to the professional liability problem.

The advantages the national specialty group programs can share with local group plans are enumerated above under the headings, "Better Insurance Protection," "Control of Procedures by Physicians," "Collection of Loss Data," "No Underwriting Discrimination," and, in a limited sense, "Prevention (Safety) Programs."

The dangers of the national specialty group malpractice insurance plans may be summed up in the general statement that they divide the profession locally and are too remote to assure the physician that he will have good claims handling and, perhaps, good defense. Malpractice claims and suits have local origins and must be investigated, handled and defended locally. If all specialists and general practitioners in the local community are insured under their separate national programs, then they have lost the local cooperative and community of interest of all physicians that is so essential to prevention and to the handling and defense of claims.

Today, most cases involve two or more specialties; unity, not division is needed. The general practitioner who first saw the patient, the specialists who later assisted in the diagnosis or treatment of the patient —all often become defendants in the same suit. With each physician separately insured under his own national specialty program, the dangers and disadvantages of a divided defense are present. Each attorney tries to "get his client out" — often at the expense of creating a nonexistent case against other defendant doctors. A divided defense of unwarranted suits increases the costs of malpractice to the profession. All doctors in a given community, regardless of practice, should be insured under the same carrier. Only under such local group programs can there be a united approach to a common problem.

In any given local area, a national specialty program will probably lack sufficient concentration of insured doctors to provide the volume of claims and suits necessary to produce **locally** the expert and experienced claims personnel and malpractice defense attorneys so desperately needed by the physician when he is sued. Claims must be investigated and defended locally.

National specialty societies can join the needed campaign to educate physicians in the causes and prevention of malpractice claims and suits. But all of the actual prevention must be done at the local level, with the cooperation of physicians in all types of practice, or it will not be done at all. For example, there is reliable information that proper hospital staff organization, with adequate supervision and control of the professional work, results in a low incidence of suits and claims against the physicians who work in the hospital. In other hospitals, where there is little or no staff control over the professional work, the incidence of claims and suits against physicians on the staff is far greater. It becomes clear that effective medical staff organization is an important factor in malpractice prevention; this cannot be accomplished by national programs that divide the staff members. It can be accomplished only by local cooperation of physicians in general practice and in all the specialties, with a common interest in a single local malpractice program.

Most of the causes of malpractice claims and suits require local treatment by a unified local profession. Causes vary from state to state — even from county to county. The applicable law is different in every state. The national specialty societies can help in solving the problem only through the use of their excellent facilities for professional education. They cannot take the local action necessary to malpractice prevention.

Consequently, it is suggested that physicians set up local group programs for the handling of professional liability insurance. Whether this be set up on a county, regional, or state basis depends upon factors such as the geography and size of the state. The important point is that a local group program, properly conceived and operated, has greater potential than either individual coverage or national specialty group coverage.

TYPE OF CONTRACT AND EXCLUSION CLAUSES

The insurance policy should contain a broad definition of the acts or omissions insured against, that is, all claimed malpractice, errors or mistakes, breech of implied contract, assault, battery, slander, etc. Some of the deficiencies found in representative professional liability insurance policies involve the way they exclude coverage for alleged criminal acts such as assault and battery or abortion, guarantees of diagnosis and treatment, restrictions as to use of fluoroscope and performance of medical practice under the influence of "drugs," and certain hazardous procedures such as spinal anesthesia.

It is certainly clear that the insurance carrier should not be obligated to pay for claims or judgments resulting from criminal acts. However it is likewise clear that such charges may be erroneously brought against the physician by the patient and consequently a proper policy should not exclude **defense** of the physician for these charges. The contract may properly exclude **indemnity** for claim or judgment but the physician should first be found guilty of these charges. In other words, it should be up to the court — not the insurance company — to determine whether the doctor is guilty of a criminal act or is practicing under the influence of alcohol or narcotics.

The use of terms such as "practicing under the influence of drugs" is potentially detrimental to the physician since the term "drugs" includes practically any type of medication. If the physician takes a capsule of a barbiturate to promote sleeping for the night, an alleged act of malpractice performed during that night could be excluded by the company not only for payment of a claim or judgment but also for defense, since properly speaking, a barbiturate is a "drug." To summarize this point, there should then be no exclusions as to the obligation of the carrier to defend. Exclusions should apply only to the **indemnity** for criminal acts, or acts undertaken by the physician while under the influence of **narcotics** or **alcohol.**

This also brings up the important point of the "guarantee of diagnosis or treatment." Again, there should be no exclusions as to obligation of the carrier to **defend** for such alleged guarantee to the patient. If, in the trial of the case it becomes apparent that the physician was guilty of guaranteeing the diagnosis or treatment, then it would be proper for the insurance company to refuse to indemnify.

In some insurance policies, there is an exclusion of coverage for the use of "hand flouroscopes." This is a deleterious exclusion clause for the physician, since the term "hand flouroscope" is rather general. Does this term apply to the flouroscope generally used by the physician in present day practice? Or does it apply to the portable flouroscopic screen, commonly used many years ago, with regular x-ray apparatus? Consequently, such exclusions for hand flouroscopes should not be accepted by the physician, unless there is a clear definition of what the term "hand fluoroscope" means.

The exclusion of certain types of hazardous procedures such as the caudal or spinal anesthesia is again detrimental to the insured. As physicians, we realize that hazardous procedures from time to time have to be employed for the benefit of the patient. Consequently, it is necessary for the insurance carriers to cover such hazardous procedures, provided the physician is willing to pay an appropriate premium for the hazard involved. Other types of medical procedure or treatment which are specifically excluded by the insurance carrier should be considered with a great deal of suspicion by the physician.

There should be a provision that there can be no settlement of a claim without the written consent of the insured physician, or a committee representing the group program (if the physician holds a policy under a group program). In other words, the physician should have the privilege of determining whether or not he wishes to have the case settled, or he should delegate this privilege to colleagues who constitute a committee for review of his case. The physician must be careful in this respect that the policy does not include qualifying clauses as to the settlement which provide that the physician must pay the difference between the amount of a judgment and the amount for which the carrier could have settled the claim if the physician had not insisted upon defending it.

Finally, the physician should not accept an insurance policy in which the exact names of his insurance carriers or a combination of such carriers and their appropriate percentages of coverage are not specifically named. He should not accept a policy with a general term indicating a group of carriers without having in hand the specific enumeration of the insuring companies and their addresses. This is particularly important in some contracts in which the broad terms "Lloyd's Underwriters and/or Other Companies," "British Companies" or other vague identifications are used. The importance of this is that ten or fifteen years later, the brokers who sold him the contract may no longer be in existence and, consequently, the physician will not then know the specific company to which he must apply for defense and payment of a claim.

CANCELLATION CLAUSE

Insurance carriers, wishing to protect themselves against continuing bad risks, usually include a cancellation clause in their insurance policies. This clause is extremely variable, ranging anywhere from a statement which provides that the policy may be cancelled on a ten-day written notice to the holder, up to group insurance provisions that the policy may be cancelled only at the end of a given policy year. In this respect, it is clear that for his own protection the physician should secure a favorable cancellation clause.

If the physician accepts an insurance policy with a ten-day cancellation clause, he suddenly may find himself with a letter served upon him in which he is informed that within ten days of the mailing of the letter he no longer has professional liability insurance coverage. Most group programs specify that the policy may be cancelled only after a given contract year, or that only a certain percentage of those covered under a given contract year may be cancelled upon a ten-or-thirty-day notice. Here again, is an example of the added protection of group coverage in contrast to individual coverage.

CONTINGENT PARTNERSHIP COVERAGE

Doctors who are in partnership or in group practice should realize that they are responsible for the acts of their partners or other members of the group. If a judgment is rendered against a partner or a member of a group, and the physician against whom the judgment was entered does not have sufficient coverage to meet the requirements of the judgmnt, the partnership or group may have its assets attached for full payment of the claim. Consequently, the physician who is in partnership or in a group should realize that he needs what is termed "contingent partnership" liability coverage.

Such coverage is ordinarily obtained with most insurance carriers by the payment of an additional premium, the amount of which differs from company to company and depends of course on the amount of coverage which the physician carries. In the lower brackets of coverage, the additional premium for contingent partnership liability may be relatively high, ranging up toward 40 or 50 per cent additional premium for the very low limits of $5,000/$15,000. As one approaches the higher limits of coverage, this additional premium decreases.

The physician with partnership liability should realize that he may have no such protection unless contingent partnership liability coverage is specifically expressed in his policy.

AMOUNT OF COVERAGE

Maximum limits of liability offered by the insurance company should be available in an amount of not less than $100,000 per malpractice incident and $300,000 per contract year. The physician should be permitted to select lower coverage limits within the standard brackets up to the amounts of $100,000/$300,000 per contract year. Those engaged in particularly hazardous types of practice may wish to secure coverage in excess of $100,000/$300,000 per year. There is no more miserable person than the physician who has a coverage of $10,000/$30,000 or $25,000/$75,000 when he is sued for $100,000 or over. The physician should remember that he must protect himself against financial ruin by securing adequate malpractice insurance coverage.

PREMIUM RATES

Medical malpractice insurance premiums, like premiums for other types of insurance, are calculated on the basis of the total of expected losses plus expected expenses. In the best circumstances when accurate data are available on previous annual losses, the insurance carrier takes this data into account and adds to it the cost of administering the program (sales, federal and state taxes, home and district office expenses, and employees' salaries), costs of special investigation, court costs, attorneys' fees, and agents' or brokers' commissions, if any, to arrive at a given annual premium. In the case of a stock company, a fair dividend return to the stockholders is included in the expenses. In the case of a mutual company, a part of the profit resulting from a given year's operation is added to general reserves and the balance is returned to the policyholders in the form of a dividend.

The calculation of premiums for medical malpractice insurance is extraordinarily difficult due to the factors of latent liability, inflation, and increasingly critical attitude of the public and the generosity of juries in awarding higher and higher judgments. Therefore, medical malpractice premiums are at the very best set by an educated guess.

Consequently, the physician should realize that his premiums are calculated on as scientific a basis as is possible under the circumstances. He must not be misled by an insurance carrier which offers a professional liability policy at an extraordinarily low premium. If such is offered to him, he should even more carefully read his policy, determine who the carrier is, what their experience is in the field, and critically survey exclusion clauses to make certain that important segments of protection are not excluded. In insurance, as elsewhere, one gets only what one pays for. A "cheap" professional liability policy can be very expensive when one is sued. A physician should not buy a professional liability policy on the basis of price alone; quality of the policy and adequacy of coverage and services are infinitely more important considerations.

Here again, a group program is to be desired, because the carrier usually agrees to provide data on losses to support premiums. The individual policyholder is entirely at the mercy of the company, since no insurance carrier is going to release to him as an individual its complete financial accounting with respect to malpractice policies in his area.

DEFENSE OF CLAIMS AND SUITS

The physician should be satisfied that the insurance carrier has an experienced and adequate investigation staff, and that it will employ a defense attorney who is competent to analyze and defend a medical malpractice case. As emphasized above, this point is of particular importance because medical malpractice insurance is a very highly specialized field. Claims adjustors and investigators and attorneys who are experienced in the general field of personal injury may not necessarily have the proper knowledge adequately to process and defend a medical malpractice case.

SELECTION OF PHYSICIAN POLICYHOLDER

Eligibility to obtain a malpractice insurance coverage should be available to any physician in good standing in his medical community. No physician should be denied the privilege of securing malpractice insurance coverage, nor should his contract be cancelled because, in the patient's interest, he is practicing in a hazardous field of medicine or surgery. To be sure, the insurance carrier should have the privilege of setting the premium properly to reflect the hazard which the physician's practice presents, but in this day and age it is most imperative that physicians' policies not be summarily disapproved or cancelled because their practice represents an unusual risk.

The only cause for rejecting a physician for coverage or for cancelling his contract should be low individual quality of practice and not the fact that he is in a hazardous field. Evaluation of the quality of practice should of course be made by physicians.

459 30th Street (Doctor Sadusk); 111 Sutter Street (Mr. Hassard); 450 Sutter Street (Mr. Waterson).

Alaska Depament of Health News

EDWIN O. WICKS, M.D., Director of Public Health
Alaska Department of Health and Welfare

Dr. Wicks

State Health Agency personnel will join with Alaskan physicians and the AMA in a concerted effort to upgrade the population's immunization status with respect to smallpox, tetanus, diphtheria, pertussis, polio and typhoid-paratyphoid. A special Federal grant of some $80,000 has been obtained for support of the drive during the next year and the PHS has loaned a trained project manager, Reimer Schultze, to coordinate all facets of the program. In addition to Mr. Schultze there will be 3 PHNs, several clerks, an Information Specialist and a microbiologist assigned to the work. Biggest headache foreseen is the corraling of larger-city residents in doctor's offices or health center clinics, the general mobility being what it is.

* * *

More than 440 active and probably active cases of tuberculosis were found during 1963, which will push our new infections rate well above that of any recent year. Undetermined as yet is whether this load represents a real increase or reflects refinements in case detection. For several years Alaska has been moving toward earlier identification of infections, earlier treatment in hospital or outpatient status, and consequently has more energy to meet the problem in its first stages. Greatly improved medical resources of the Native Health Service and establishment of private practices have contributed markedly to the present state of affairs.

Frank Pauls has followed Ralph Williams in receiving a USPHS educational scholarship to permit work toward a doctoral degree in laboratory science. Both men are enrolled in the University of North Carolina School of Public Health, with stipulated residence also at the Communicable Disease Center in Atlanta, and both will return to work with the Division of Public Health on completion of their studies.

* * *

Dr. Robert I. Fraser, once MOC of Kotzebue ANH Hospital and last summer consultant in tuberculosis to the Division, will return to the State in April to assume responsibility for the Tuberculosis Control Unit. Dr. Fraser and his wife, who is also a physician, are now in Europe after completion of a six month's fellowship in Chest Diseases in London which capped-off his residency in Internal Medicine.

* * *

During the last several years the Research Council of the National Academy of Sciences has utilized the professional knowledge of A. J. (Joe) Alter, Chief Engineer of DPH, on special committees. He is presently Secretary of the Waste Disposal group and prime authority on Arctic environmental problems. Last November Mr. Alter was Chairman of special engineering symposia at the Purdue conference on Polar life. The year before he was widely quoted at the WHO Geneva meetings which discussed research and advances of understanding about both Arctic and Antarctic areas. Many of his publications of the late 40s and early 50s have enjoyed continued reprint popularity as the only materials of their type.

* * *

ALASKA'S HEALTH PLAN, which outlines the organization of the State Department of Health & Welfare in general and details operations of the Divisions of Public Health and Mental Health specifically, has been approved by the PHS-DHEW which manages participation of the Federal Government in many categorical health programs. Sufficient copies of the comprehensive volume are available so that early requests for it may be honored. Address the Divisional Office, Juneau 99801, or the nearest Regional Health Officer.

* * *

The Ketchikan Public Health Laboratory closed out 20 years of useful service to practitioners and the community when it was deactivated last December 31st. Opened during the war year 1943 the lab had its greatest purpose before air transport was developed and through the time that private and hospital facilities were non-existent or sketchy. The new Ketchikan General Hospital Laboratory with consultant services available in clinical pathology can fulfill personal needs of Gateway Borough while specimens of public health importance will be routed to the Southeastern Regional Laboratory in Juneau. Only three microbiologists had charge of the lab in its two decades: Mrs. Dixie Baade, Mrs. Jane Webber Carr, and Mrs. Adelaide Gregory — and all of them still reside in Ketchikan.

* * *

Reductions in health program funds at the national level will decrease Alaska's entitlements next fiscal year by $26,400. Sorely felt will be the loss of $15,000 in the Tuberculosis Control grant and $11,400 of General Health monies. The critical needs for both operations have been pointed out to the Bureau of the Budget and our Congressional delegation in view of Alaska's major problems and high costs, but little hope is entertained for removal of the threat. Laudable efforts to enforce effective use of public funds thus turn out to damage jurisdictions remote from the Capitol scene and despite pleas for understanding flexibility in professional areas.

* * *

Edward S. Leigon, now with the Nursing Home Construction and Licensure Section of the Florida Board of Health, will arrive in mid-March to take over management of Alaska's Hill-Burton program and related activities. Mr. Leigon replaces Lloyd Morley who moved up to the desk of Administrator in the Public Health Divisional Office.

* * *

A radiation analyzer has been purchased by the Department and set up as part of its radiological health program. The equipment is expected to go into operation early in 1964 and initially samples of meat, water, vegetation and possibly some marine life from sampling points throughout Alaska will be collected and sent to Juneau for analysis.

NOMINATIONS ACCEPTED FOR TWO AWARDS

The ASMA Council will single out two physicians for special awards at its meeting in Ketchikan on May 26, 1964, and ASMA members are requested to submit their nominations for these awards to the office of the Secretary, 718 "K" Street, Anchorage.

The awards are as follows:

The A. H. Robins Company Community Service Award, accompanied by a handsome bronze medallion on a mahogany plaque, awarded to a physician who has rendered outstanding service aside from his usual medical activities.

The ASMA Physician of the Year Award, given to a member for unique or outstanding performance as a physician.

U. S. P. H. S. News

An area-wide conference of key Alaska Native Health Service Hospital staff members was held in Anchorage the week of February 17. Discussion centered on "How the Village Can Meet Its Health Needs" and on "The Development and Implementation of a Village Health Program." Speakers during the conference included Dr. Ivar Skarland of the University of Alaska, who discussed anthropological aspects of village life among the Alaskan natives, and numerous members of the medical and paramedical Public Health Service personnel who discussed various aspects of health problems in the villages.

On the final day of the conference Dr. Holman Wherritt, the Area Medical Director introduced a combined research-demonstration project which will be a cooperative effort between the USPHS and the Office of Vocational Rehabilitation to start about April 1, 1964. This project, financed by a three year federal grant, is concerned with the rehabilitation of patients after discharge. The following section from the proposed project prospectus explains some of the background of the project:

All patients are Alaskan natives; these are comprised of four separate and quite different ethnic groups, and number approximately 43,000. They are the Eskimo, the Inland Indian, the Aleut, and the Southeastern Indian. Instead of using the cumbersome term "Alaskan Native Races," we have chosen to use the term "the People." This is the approximate term each group, in its own tongue, uses to describe itself. It connotes a certain dignity, self-sufficiency and completeness which we would like to honor and to strengthen where we can.

The People at present are struggling back from the brink of extinction by repeated disasters in many forms. The survivors represent a mere fragment of their former strength. In all of human history, it is seldom that such a fragment so shattered has been able to endure. Many of the People have come through this ordeal severely traumatized and badly disabled.

The People have endured, and have indeed thrived, for many thousands of years in a very harsh environment with few material assets. They have great energy, foresight, and a capacity for organization. They studied their environment and developed survival skills that modern white man's technology has been unable to equal. Their basic genius was their ability to engage in cooperative endeavor within well organized groups of mutually dependant people under their own strong leadership. Their codes of behavior were strong and were characterized by the necessity for the People to maintain relationships that would keep the spirit of men and animal friendly to one another.

Life for the People was a happy experience, and while each season brought hunting accidents and tragedy to a certain almost predictable number, this was accepted as a part of their lives. Their code provided great honor and appreciation to these hunters while they lived and when they died, the loss was accepted with a relative equanimity. Each person had a function, a status, and a certain dignity in his village. Under these circumstances, the People were sturdy, resourceful, amiable and optimistic. Some of these characteristics survive to this day, making tne People a charming, personable, and responsive group of individuals with whom to work. In the past two centuries however, the People have been visited by disaster in many forms. The coming of the white man broke the barrier of isolation that had served to protect them through thousands of years. Devastating epidemics swept the land and illnesses that were considered fairly innocuous among outsiders were often fatal among the People. During the nineteenth century, epidemics of measles, influenza and smallpox took a terrible toll. Tuberculosis also apparently was introduced by the white man, and under Alaskan living conditions, found circumstances ideal for its widespread dissemination. The epidemic of tuberculosis increased during the past three decades until it became obvious to all that the continued existence of the People actually was threatened. All agencies, missionaries, traders and other individuals, were swamped by the enormity of the problem. At the urgent request of the Department of the Interior, a committee was appointed to study the problem. This committee was headed by a former Surgeon General of the USPHS, Dr. Thomas Parran. Dr. Parran and his group of eighteen consultants studied the problem for a year and a half and documented the severity of the problem. The sober conclusions drawn by this group were that the morbidity and mortality related to tuberculosis was astronomical and exceeded in severity anything so far recorded in the annals of Public Health, even in the poorest areas of China where tuberculosis was rampant. They further concluded that existing staff and facilities for tuberculosis were completely inadequate to solve the problem. They recommended that a "crash" program — a massive attack — be planned and implemented. This massive attack was executed by means of utilization of every possible facility that could be commandeered into service. The results of the attack were brilliantly successful, and the dramatic decline of morbidity and mortality is one of history's most outstanding public health accomplishments. Many agencies, groups, community organizations and individuals can properly share in the credit for this accomplishment. It required and received a prodigious cooperative effort and was an exceedingly costly undertaking. However, there can be no question but that the heaviest cost was borne by the People themselves; hospitalization represents a great ordeal to them but they accept it with gratitude, and endure it with graciousness and patience. The irregular discharge rate among the People is so low that it is unbelievable to our colleagues in the "small" states. The results of treatment were almost uniformly good, and the incidence of treatment failure was remarkably low.

In spite of the fact that the People accepted the death with equanimity, the family separations with courage, and the painful and hazardous procedures with stoicism, they paid a great price for the victory. The epidemic had resulted in death, separation, and chronic illness; in family disruption, social demoralization and despair. There has been a breakdown of cultural customs of training the young in the arts of survival, and in the social code of meeting mutual needs through cooperative group efforts.

The young men of working age, and the young women in the child-bearing age, were children themselves during the worst ravages of the epidemic. For years, several of us have made it our custom to ask each patient the question: "Were you raised by both of your parents?" We have found it to be rather an unusual circumstance for any of the People to have been raised by their own parents. The typical story is this: when the patient was one or two years old, the mother died in the home of a pulmonary hemorrhage. The father tried to keep the family together with help of relatives (many of whom were in the same situation); before very long, however, survey films showed that the father and several siblings also had tuberculosis. Hospitalization was arranged, the family scattered and the patient spent the majority of his childhood being passed around among the desperate surviving relatives, or in crowded orphanages, Government boarding schools, or were themselves hospitalized for long periods of time with tuberculosis. These facilities were swamped and were unable to provide the warmth, the variety of experience or training even in the simple arts of communication. Many of these young people have serious language handicaps, both in the native language and in English. Emotionally, many bear the scars of social deprivation during these formative years. The language handicap has prevented them from taking full advantage of the limited academic opportunities which have been available. They see no way out of this predicament; they have no means for rescuing themselves, and the present mood of the People is one of deep depression amounting to actual despair. Many seek their solace in alcohol. The condition of alcoholism seems to be replacing tuberculosis as the major threat to the People. Thus the People are a group adrift, hampered by a formidable multiplicity of handicaps; caught in economic deprivation, economic hardship leading to despair and despair leading to more disease. A practical and comprehensive rehabilitation program is the only weapon that would be effective in interrupting this vicious circle.

One of the basic recommendations of the Parran Report was that the "plight of the native be understood for what it is — the slow death of once proud and self-sufficient races. To survive they need health care, food, and housing; to become self-respecting men and self-sufficient citizens, they need education, employment, vocational and professional training."

The time is now ripe, and indeed is past due, that a project be designed and implemented to study the People with their strengths and their handicaps, to provide the opportunities that would enable them to live in their land or, if it is feasible, to equip them to go where they will.

Those patients meeting selection criteria will be evaluated with regard to their medical-social status as it relates to rehabilitation. Initially, at the time of admission, each selected patient will be given a questionnaire so designed as to seek basic data on socio-economic adjustment and current attitudes. From the data collected, patients will be selected who will most likely benefit from the rehabilitation program. An intensive study of those selected will then be undertaken which will include application of a battery of tests and interviews to determine intelligence, achievement aptitude, adjustment and motivation. From the data collected, an objective appraisal of the individual will be made and a plan of rehabilitation developed. The plan will be reviewed with the individual and acceptance of it determined. Through motivation of the individual and readjustments of the plan, an acceptable plan will be coordinated. To assure effective rehabilitation, it will be essential to evaluate the interaction between the Alaskan Native and his environment. This will be done by determining interaction with established groups within the hospital, and with naturally occurring community groups. Methods will be devised to motivate the community to improve opportunities for the rehabilitated Native and provide a healthier environment. This is felt most important for the success of the rehabilitated individuals; without a healthy environment, most rehabilitation will be for naught.

All throughout the above process, questionnaires, techniques, and methods will be developed to collect data which can be statistically treated in such a manner as to evaluate the program and predict who can be rehabilitated - to what extent, and how.

* * * *

Dr. Lowell R. Hughes is the new Clinical Director at the Anchorage Hospital. He is a 1950 graduate of the Ohio State School of Medicine and served an OB-GYN Residency at the Columbia Presbyterian Medical Center in New York City. He is a Fellow of the Board of Obstetrics and Gynecology and came to Alaska from Albuquerque, New Mexico.

MUKTUK MORSELS

A COLUMN DEVOTED TO
MEDICAL NEWS IN ALASKA

Compiled by

HELEN S. WHALEY, M.D.

GENERAL: A Congenital Defects Clinic was sponsored jointly by The National Foundation, The Alaska Crippled Children's Treatment Center in Anchorage, and the Alaska Department of Health. Participating speakers were Dr. William O. Robertson, Assistant Professor of Pediatrics and Assistant Director of the University Hospital of the University of Washington, and Dr. Frederick Hecht, M.D., Geneticist at the University of Washington. Approximately 40 children from all parts of Alaska with a large variety of abnormalities were reviewed on January 17 and 18. A.A.G.P. credit was offered for the session.

A Nurses Clinical Conference was sponsored jointly by the Alaska Nurses Association and the Alaska Heart Association on January 29 and 30 discussing the role of the nurse in the management of the patient with heart disease. A number of Anchorage physicians participated in the symposium, including Drs. Robert Wilkins, Lester Margetts, Gilbert Blankinship, Robert and Helen Whaley, Rodman Wilson, and Louise Ormond. The role of surgery in the care of the heart patient was outlined, and there were additional sessions on closed chest cardiac resuscitation, myocardial infarction, and the rehabilitation of the patient with a cerebral vascular accicent. This was held at the USPHS ANS Hospital and was organized by Sister Philias of the Anchorage Providence Hospital. A similar session was also held in Sitka with the participant physicians being: Drs. Henry Akiyama, Juneau Clinic internist; Homer Ray, Acting Chief of Mental Health; Robert Shuler, Sitka; Edward Spencer, Sitka; Charles Anderson, Mt. Edgecumbe Pediatric Chief; E. C. Gaenshen, Mt. Edgecumbe Chief of Medicine; and George Langenbaugh, Mt. Edgecumbe Chief of Surgery.

Dr. Karl M. Bowman, a 1913 graduate of the University of California School of Medicine, who was formerly Professor of Psychiatry at the Langley-Porter Clinic of the University of California School of Medicine and is a diplomat of the American Board of Psychiatry and Neurology and a member of the American Psychiatric Association, will assume the double duties of the Director of Mental Health and Director of the Alaska Psychiatric Institute in Anchorage in March. Dr. Bowman is considered an outstanding authority in the field of psychiatry and has helped set up a number of mental health programs, including the one at the Langely-Porter Clinic and one in Indonesia.

The Alaska Medical Political Action Committee for 1964 consists of the following Chairman, Dr. Royce Morgan; Secretary-Treasurer, Dr. Michael Beirne; Board of Directors, Drs. Milo Fritz, Calvin Johnson, Robert Holmes Johnson, Don Val Langston, Joseph Ribar, T. M. Moore, and Robert Wilkins.

The Lederle Symposium was held in Anchorage on Saturday, February 22, under the joint sponsorship of the Anchorage Medical Society, the Alaska Chapter of the American Academy of General Practice, and the Lederle Laboratories. During the morning sessions Roger D. Williams, M.D., Professor of Surgery at Ohio State University College of Medicine, spoke on "Some Observations in Jaundiced Patients and Partial Biliary Obstruction"; Leslie J. DeGroot, M.D., Assistant in Medicine, Massachusetts General Hospital and Associate in Medicine at Harvard Medical School, reviewed "Hashimoto's Thyroiditis and Its Immunologic Aspects"; and Nicholas P. Christy, M.D., Associate Professor of Medicine, Columbia University College of Physicians and Surgeons, discussed "The Effect of Long Term Steroid Administration on Hypothalamic-Pituitary-Adrenal Function."

Over 115 physicians attended the sessions, travelling from all parts of Alaska. The Kenai Peninsula was represented by Dr. John Fenger of Homer, Dr. Paul Isaac and wife of Soldotna, Dr. Allen Barr of Kenai, and Dr. Ernest Gentles of Seward. Drs. Henry Wilde and Jack Lesh represented Juneau; Dr. Chester Schneider, Glennallen; and Dr. John Shadler, Nome. The clinic prize for attendance, however, went to the Tanana Valley Clinic in Fairbanks which had three of its members, Dr. Donald Tatum, Dr. F. L. Gobble, Jr., and Dr. Ben L. Bachulis present for the symposium.

LOCAL NEWS:

NOME: Dr. John Shadler spent Fur Rendezvous week in Anchorage attending sessions at the USPHS MOC Conference and the Lederle Symposium. Dr. Shadler plans to spend 2 months near Bombey, India, in a 150 bed Methodist mission hospital, doing surgery while the resident surgeon returns to the States.

SAND POINT: An ear, nose and throat clinic was held recently under the auspices of the resident physician, Dr. Carl Sandburg, and visiting consultant, Dr. Mahlon Shoff of Anchorage.

VALDEZ: Staff members of Harborview Nursing Home are busy making final plans for the rennovation this summer of the unoccupied buildings in the unit which will provide at least 50 more mental health beds.

JUNEAU: Dr. and Mrs. Henry Wilde and family vacationed for a month in Mexico this winter. Dr. and Mrs. Jack Lesh spent Rendezvous week in Anchorage attending the MOC Conference and the Lederle Symposium and also watching their sons Pete and Jon compete with considerable success in the Alaska High School Ski Championships at Mt. Alyeska.

SELDOVIA: Osric H. Armstrong, M.D., who practised in Alaska a number of years ago, has returned to this community which has been without a physician for approximately a year since the drowning of Dr. Philip Cary Whitehead. The community has been given medical service twice a week on an itinerant basis by Drs. Gaede and Isaak of Soldotna.

SOLDOTNA-STERLING: A community hospital project has been initiated under the leadership of Dr. Paul G. Isaak. An attempt is being made to underwrite this 32 bed hospital on a private basis through the sale of stock. A site has been selected in the Soldotna Junction Subdivision and thus far local stock sales are promising. Anyone interested in participating or learning more about the plans should write to Dr. Isaak directly at Box 345, Soldotna. At present all deliveries are done in the clinic of the two doctors, where mother and infant stay overnight, and are then discharged home. Most surgical and seriously ill patients are required to go to the hospital approximately 100 miles away in either Seward or Anchorage.

PALMER-WASILLA: During the Christmas holidays Dr. Boyd Skille returned to Minneapolis. He drove a new car up the highway for Dr. Walter Cunningham, his associate.

FAIRBANKS: Two new physicians have entered practice in the Fairbanks area. They are Drs. F. L. Gobble, Jr. and Ben L. Bachulis, both of whom are associated with the Tanana Valley Medical and Surgical Clinic. Dr. Bachulis was formerly in the Army. He is a 1960 graduate of the Ohio State University College of Medicine and is a general surgeon. Dr. Gobble, formerly of Winston-Salem, North Carolina, was a graduate of the Bowman-Gray School of Medicine in 1944. He is a diplomate of the American Board of Obsterics and Gynecology and a member of the American College of Obstetricians and Gynecologists.

The medical staff of St. Joseph's Hospital elected the following officers in December; President, Dr. Joseph Ribar; Vice President, Dr. George Leih; and Secretary-Treasurer, Dr. James Lundquist. Dr. Charles T. Marrow was elected President of the Fairbanks Medical Society, with Dr. George Clark to serve as Vice President, Dr. George Leih as Secretary, and Dr. Edward Meyer as Treasurer.

Dr. James Lundquist attended the National Congress on Medicine and Pharmacy in Chicago on March 12-13 as a representative of the Alaska State Medical Association. This Congress is the first project of the newly formed Commission on Medicine and Pharmacy of the American Medical Association and was designed to promote a closer liason between medicine and pharmacy. The program included discussions on Ethical and Legal Liabilities in Medicine and Pharmacy, Interprofessional Relations, Physician-Owned Pharmacies, Renewing of Prescriptions, The Economics of Medical Care, and other topics of general interest.

ANCHORAGE: The 1964 President of the Anchorage Medical Society is Dr. Rodman Wilson. President of the Providence Hospital Staff is Dr. Don Val Langston, and President of the Presbyterian Hospital Staff is Dr. George Hale. President-elect of the Anchorage Medical Society is Dr. Lester Margetts and of the Providence Hospital Staff is Dr. Theodore Shohl. Dr. Robert Wilkins was reelected to a second term as President of the Greater Anchorage Health District. He has been an active board member for ten years.

Drs. William Mills and Robert Whaley attended an international cold symposium in Fairbanks during the latter part of February. During much of the month Dr. Mills participated in the operation "Freeze" troop maneuvers in the Big Delta region near Fairbanks.

In January, Drs. J. Ray Langdon and William E. Davis, Professor of Psychology of Alaska Methodist University, represented Alaska at the Western Interstate Commission for Higher Education meeting in Boulder, Colorado. Drs. Robert Wilkins and Allen Homay are members of the new fund-raising committee set up at the Alaska Methodist University.

Various parts of the world were visited by a number of Anchorage physicians. Dr. Winthrop Fish explored the lower western coast of Mexico. Dr. Rodman Wilson visited his family who are spending a year in Tangier, Morocco, and took a cruise during the Christmas holidays to Italy. Drs. Virginia Wright and James O'Malley visited Spain. Dr. George Hale attended the Winter Olympics and skied in a number of European ski centers. Dr. Robert Wilkins attended the American Heart Association meeting in Scottsbluff, Arizona, in January, and Dr. John Tower was in Tucson for the regional meeting of the American Academy of Pediatrics in March.

Dr. Donald Kettelkamp successfully completed his Orthopedic Boards in Chicago, and Dr. Fred Strauss was examined and certified by the American Board of Pathology in anatomical and clinical pathology in San Francisco in November.

Dr. Gilbert Blankinship attended the Congress on Medicine and Pharmacy in Chicago in March as a representative of the Alaska State Medical Association along with Dr. James Lundquist of Fairbanks.

Two new physicians will enter practice in the Anchorage area. These include Dr. Alistair C. Chalmers, formerly of Winnipeg, Canada, and originally from Scotland, who will practice urology. He is a 1955 graduate of the University of Glasgow, Scotland, and will arrive in Anchorage with his wife this spring. He has had general surgery, orthopedic, pathological and urological training in Glasgow and more recently at the Winnipeg General Hospital. He has been in private practice in urology with the Manitoba Clinic in Winnipeg since July 1962.

A new family physician will be added to the staff of the Doctors Clinic when Dr. Tryon Wieland leaves the Air Force soon. He is a 1960 graduate of the University of Pennsylvania School of Medicine. He has spent considerable time in the Orthopedic Clinic at the Air Force Hospital.

Seminar on Psychiatric Techniques for the Practicing Physician

Presented by the Department of Psychiatry, University of Utah College of Medicine, in cooperation with the Anchorage Medical Society

Anchorage-Westward Hotel **Saturday, March 28, 1964**

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SPEAKERS

10:00-10:50 a.m.—Office Management of the Demanding Patient. Lindberg S. Sata, M.D.

11:00-11:50 a.m.—Depression, Suicide, and Its Importance to the Practicing Phycision. C. H. Hardin Branch, M.D.

10:00- 1:30 p.m.—Lunch.

1:30- 2:15 p.m.—Drugs in the Management of Patients with Emotional and Mental Problems. Herbert B. Fowler, M.D.

2:15- 3:00 p.m.—Hypnosis and "Suggestive Techniques" for the Practicing Physician. Lindbergh S. Sata, M.D.

3:00- 3:30 p.m.—The Family Physician and His Role in Community Psychiatry. C. H. Hardin Branch, M.D.

3:45- 5:00 p.m.—Panel discussion — including the speakers and Dr. Langdon. Topics given above and any other subject matter brought forward by those in attendance will be discussed by the panel.

C. H. Hardin Branch, M.D.
Professor and Head, Dept. of Psychiatry, U. of Utah College of Medicine. Immediate Past President American Psychiatric Association.

Lindberg S. Sata, M.D.
Sr. Staff Psychiatrist, Dept. of Psychiatry, U. of Utah College of Medicine

Herbert B. Fowler, M.D.
Director, General Practitioner — Psychiatry Education Project, Dept, of Psychiatry, U. of Utah College of Medicine

J. Ray Langdon, M.D.
Practicing Psychiatrist, Anchorage, Alaska

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Alaska Medicine

Volume VI, No. 2 June, 1964

DISASTER ISSUE

Dedicated to the physicians of South Central Alaska who suffered personal loss in the March 27, 1964, earthquake and tidal waves

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ALASKA MEDICINE

Official Journal of the Alaska State Medical Association

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PSYCHIATRIC ASPECTS OF MARCH 27, 1964, EARTHQUAKE

J. Ray Langdon, M.D., Psychiatrist; Allen H. Parker, Ph.D., Clinical Psychologist
ANCHORAGE, ALASKA

Presented at the Meeting of the American Psychiatric Association, Los Angeles, May 1964

As might be expected from the nature of emotional reactions, the psychiatric aspects of the earthquake have been slower developing than the physical, and it is to be expected that there will be multiple long-term developments. Therefore, this is in the nature of a preliminary report.

It is important to note that there are "normal" reactions in the face of danger. The accompanying table has been drawn up by us from anecdotal accounts of this disaster, but it seems to be similar to accounts we have seen of other disasters. From exaggerated responses in these various areas seem to derive the psychopathological reactions described below. It is also notable that both the normal and pathological reactions change with time and also with subsequent circumstances.

The first concern psychiatrically at the time of a disaster is the amount of panic developing which may either cause more physical casualties, hamper rescue operations, or paralyze vital functions. Panic may be either blind running or "freezing." For all practical purposes, in the early hours of the disaster there was no panic, and the community as a whole was not damaged by this reaction. The subsequent impulsive departures Outside probably represents modified panic in many

EARTHQUAKE REACTION SCHEMA

Immediate Responses[1]		**Symptoms**[2]	**Defense Mechanisms**[3]
Disorientation	**Effort**		
Place, Person, Time	Busyness	1. Acute feeling of fear (real or potential danger)	1. Reaction formation (bravado)(calmness)
Subjective localization of Disaster.	Support for others.	2. Anxiety—acute onset including tremor, visceral symptoms, tendency toward flight.	2. Denial (disbelief)
Subjective limitation of scope.	Service to others.	3. Concern for others	3. Rationalization
	Movement (physical or psychological) towards loved ones.	4. Depersonalization (if present)	4. Catharsis (ventilation) (earthquake tales)
		5. Thrist for informaiton	5. Regression
		6. Seeking human companionship; avoidance of aloneness.	6. Projection
		7. Impairment or heightened appreciation of reality.	
		8. Guilt (particularly at being lucky).	
		9. Depression.	
		Other symptoms overlapping the above sequentially	
		Excess fatigue.	
		Changes in eating and drinking patterns.	
		Exquisite sensitivity to environmental influence.	

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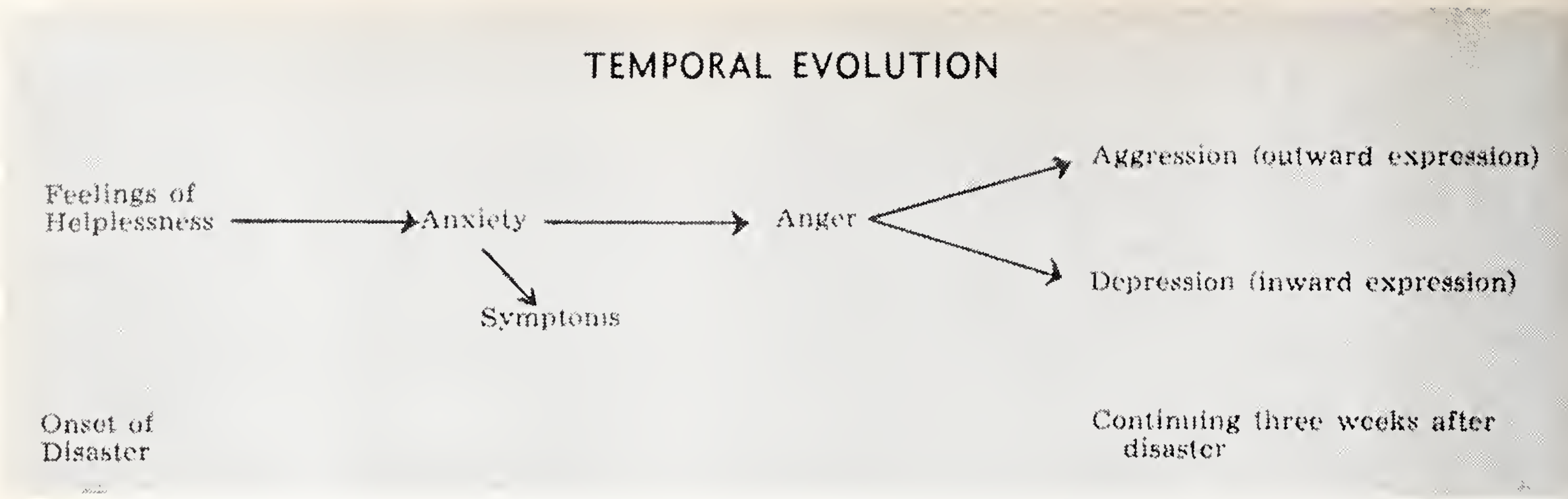
[1] Necessary to the preservation of personality integration in face of an overwhelming situation.
[2] In approximate order of onset.
[3] These are the most apparent—the list is not intended to exclude others; in approximate order of onset.


TEMPORAL EVOLUTION

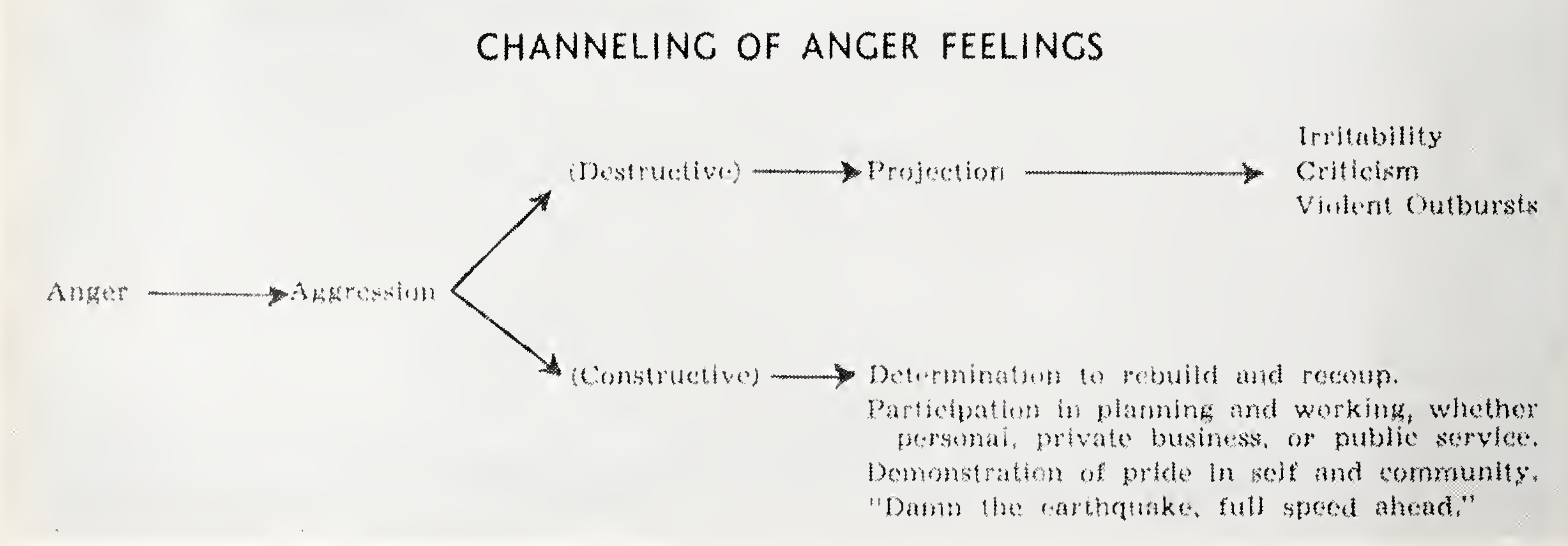
Feelings of Helplessness
Anxiety
Symptoms
Anger
Aggression (outward expression)
Depression (inward expression)
Onset of Disaster
Continuing three weeks after disaster

cases though not nearly enough of these people were seen to comment accurately. Probably there will not be any accurate documentation on this aspect of the situation.

Following the initial phase of the disaster there was a breathing space of varying lengths of time in different places and for different people. During this period people worked vigorously at surviving or getting their living conditions under some control. This work is usually done intensely and to the point of exhaustion, leaving little opportunity for emotional expression — a "numb" phase emotionally. It was expected that four days or so would pass before psychiatric casualties other than panic began to show, and this proved reasonably accurate, though obviously the initial numb phase would last longer in communities such as Seward and Kodiak where the physical effort necessarily continued longer.

The most prominent types of definable reactions were those best described as separation phenomena. This indicates an unconscious psychological separation from the overwhelming part of the disaster as determined by the individual. Some of these were pure dissociative reactions, some appeared almost like schizophrenic delusions, but all involved the removal of the self to another planet, a mythological existence, or another identity away from the quake zone. More simple but similar reactions were noted in excessive sleeping—at this point not associated with physical fatigue. So far as can be determined alcohol was not an unusually large feature of these reactions, possibly because of the normally high consumption which made it not especially useful.

At this point of prediction it would be anticipated that the communities as a whole may go through further phases of reaction, from which may develop individual pathological reactions. Recognizing that there is an underlying increase in anxiety the reaction predictions are based on this as an additive feature in the intensity of the reactions. Anger may show itself in multiple forms but is basically against the natural disaster itself. This being irrational, the anger will be rationalized toward the nearest vulnerable target-self,


CHANNELING OF ANGER FEELINGS

Anger
Aggression
(Destructive)
Projection
Irritability
Criticism
Violent Outbursts
(Constructive)
Determination to rebuild and recoup.
Participation in planning and working, whether personal, private business, or public service.
Demonstration of pride in self and community.
"Damn the earthquake, full speed ahead."

spouse, God, children, government officials, police, etc. This may show as chronic irritability, violent outbursts, or carping criticism. Naturally, many of these targets may occasionally warrant angry reactions, but the intensity will probably be much higher than appropriate.

Following this phase—and depending on how well the energies of the anger are channeled and used—may well develop a period of more or less profound depression with all the usual hazards of individual depressions—withdrawal, inertia, poor function, and suicides. The severity of this naturally will depend to some degree on the amount of recovery the community and the individual has reason to hope for, but probably it cannot be prevented entirely.

Many individual or group reactions have been noted, most of which are entirely understandable psychological reactions—the tendency of children to cluster together and sleep together; victims of some special type of disaster, such as loss of home, to seek out other similar victims; the over reaction to mild aftershocks, etc. Among the more common profound reactions, which is only partly psychological, is the massive fatigue showing after the first week or so, which had usually called forth unusual physical efforts.

Alaska's geographic and socio-economic situations may partly explain whatever differences the disaster reactions here and elsewhere may show. While it may be to some degree true that Alaskans are stoic individualists, this is not the usual finding of psychiatrists and other physicians. In part, the cool reaction at the outset may be laid to the normal inexperience with, and ignorance of the severity of earthquakes and the actual damage resulting. However, another factor is that Alaska is plainly isolated, and that for immediate purposes a person or a community is simply going to have to perform on one's own. Again, the reactions of and to those going Outside are predicated on the fact that this is a much larger step to fly 1500 - 3000 miles than to drive 100 miles to the next state or county. Probably few people who left Crescent City temporarily after their tsunami were looked upon as deserters, but in this more isolated, forbidding area, there has been some such response. Interestingly this belligerent, somewhat defensive attitude probably explains the lack of need for and reluctance to use martial law despite the size of the military component of the population.

Psychological reactions in communities not physically damaged by the quake, though not yet well-assessed, are of interest also. Both the Northern areas, such as Fairbanks, and the Southeastern communities have reported some increase in anxiety reactions, not well-defined, and other unusual behavior, such as decrease in business. Probably these are based, again large unconsciously, on the concern over the possible damage to the economic, transportation, medical, population, etc., center of Alaska-Anchorage itself, the ports, the oil industry, etc.—in other words the insecurity and anxiety felt when big brother gets clobbered until it's certain if he's going to get up.

Humor as a defense mechanism was noted within hours both in oral funny stories and comic signs. This humor was generally not the projective, destructive type, but regressive in service of the ego — most of the funny stories were about oneself or possessions. It is notable that it figured in some way in the various phases of reaction.

As is usually noted in natural or man-made disasters, severely mentally ill patients—schizophrenics, involutional psychotics, etc.—whether hospitalized or out-patients, reacted negligibly to the earthquake and continued on whatever level of function they were operating previously. Also, which may be more noticeable in a smaller community such as Anchorage, non-psychotic psychiatric patients who actually were, or had recently been in therapy, seemed to fare quite well despite being in many cases in dangerous situations or suffering individual losses. Many checked in as soon as reasonable to indicate they were all right (and perhaps to see that we were).

A matter to consider in the future report is the possible effect in Anchorage, and also in some of the smaller communities, of the tremendous personal losses suffered by many of the community leaders at precisely the time they were being called on for extra efforts for the remainder of the community. We may also be able to discover whether there was sufficient conservation of energy by public officials, city employees, etc., to permit efficient operation, and whether there will be rebound reactions from this excess effort in the face of emotional upheaval in the months to come.

As this is a preliminary survey and report with no statistics of any validity, no overall conclusions should be drawn as to the total psychological effect of this earthquake on this community. It is hoped and planned that a more detailed follow-up can be made after six months or a year, and perhaps again even later to delineate the "aftershocks" if possible.

EMERGENCY HEALTH SERVICE IN AN ALASKAN DISASTER

THOMAS R. McGOWAN, M.D., Dr. P.H.

Southcentral Regional Health Officer, Division of Public Health, Alaska Department of Health and Welfare, and Chief, Southcentral Region Emergency Health Service

SUMMARY

A plan to furnish emergency health service following a disaster had been prepared and was implemented following a severe earthquake. Services were furnished in accordance with the plan and it was possible to deal with all problems arising by utilizing local personnel, material, and facilities and by acquiring necessary additions through prepared channels.

Initially efforts were directed towards gathering information and handling urgent immediate problems. This was followed by a longer period of providing necessary services and subsequently by a continuing period of developing policies, plans and procedures for permanent correction of defects.

Despite the severity of the disaster, there were few casualties and no epidemics or other major medical problems have developed. It is believed that the effectiveness of handling disaster health problems and the absence of major medical complications resulted largely from adequate private and public health planning and preventive medical practices.

ORGANIZATION

In the Alaska Civil Defense Plan, Emergency Health Service Annexes are established at the State, Regional and Community levels. The Southcentral Region Annex, correlating with State and and Community Annexes, provided the basic organizational structure and operating procedures by which the Southcentral Region Office of the Alaska Department of Health and Welfare, Division of Public Health, located in Anchorage, functioned as the official health agency of the State in the entire area of disaster resulting from the earthquake of March 27, 1964. This Regional Annex, developed during the preceding year, provided an Emergency Health Service Chief, Branches of Administration, Nursing, Environmental Health, and Laboratories, and subsidiary Divisions, all designated positions being filled by personnel of the Division of Public Health, the Alaska Native Health Service and the Arctic Health Research Center. The mission of the Regional Emergency Health Service was to provide maximum support and cooperation to district Civil Defense officers in planning, preparedness, and provision of materiel and manpower in respect to health mobilization.

INTUITIVE PHASE

Personnel of the Emergency Health Service began reporting for duty to local Civil Defense Headquarters within minutes after the earthquake. Due to incomplete knowledge of the existing situation and to extreme difficulty of even local communications, health activities during the early hours were directed toward acquiring information, caring for casualties, providing for sanitation of essential facilities, and attempting to forsee additional problems. In Anchorage, degree of damage to hospitals and medical facilities and numbers of casualties were estimated from reports received through repeated visits by runners to various facilities and from contacts between medical representatives. As the significance of the disaster became known, specific professional personnel were summoned to duty by runner and by public radio.

With the determination that public utilities in Anchorage had been severely damaged, the Division of Public Health sanitarians in Anchorage immediately began procedures to assure safety and availability of drinking water, providing for delivery of containers of water to hospitals and public buildings, and for chlorination of the water system in one hospital. Within 24 hours these sanitarians, assisted by military and civilian personnel, had positioned 33 water trailers at schools and other central points where suitable drinking water could be obtained.

Although the initial casualty load was light, and adequately cared for by the well organized private, military and U.S.P.H.S. physicians, preparations were made for the reception of additional casualties and refugees, distribution being made of blankets and other materials from the Civil Defense Emergency Hospital pre-positioned in Anchorage. Requests were made through the Juneau office of the Division of Public Health for additional supplies, equipment and professional personnel, and as soon as communications permitted information was obtained from various communities about the availability and suitability of facilities for accommodating refugees.

A meeting of city and Civil Defense officials with the Mayor of Anchorage at 3:00 a.m. on March 28 to assess local damage and to develop a plan of operations permitted integration of community health requirements with those of other departments, and a series of meetings with officials of State, Federal and volunteer agencies later that day allowed further development and correlation of activities.

Many hours elapsed before the medical status of outlying communities was known. The Division of Public Health had at the time of the earthquake public health nurses in the Naknek, Cordova, Valdez and Palmer areas, both public health nurses and sanitarians in Seward, Kodiak, and the Kenai-Homer area. It was correctly assumed that these persons with their clerical staffs were working with their local Civil Defense organizations. Continual attempts were made to contact these representatives in order to determine and fill additional health requirements.

Reports reaching Anchorage during the first night indicated no immediate need for medical action except at Whittier, a physician being airlifted from Anchorage to Whittier at 4:20 a.m. Saturday morning to evacuate a severely injured patient. It also became known during the night that the residents of Valdez, including the patients of Harborview Nursing Home, were being evacuated to higher ground. Therefore on the following morning a public health nurse with medical supplies, accompanied by one of several Fairbanks physicians who had volunteered their services, was flown to Valdez to assist the local physician and public health nurse in evacuating the patients to the Alaska Psychiatric Institute and the remaining population to the Fairbanks and Glennallen areas. Two other Fairbanks physicians were sent to Seward to furnish assistance as necessary before returning home.

During the morning of March 28, Anchorage public health nurses gathered necessary materials and began to organize for mass immunization against typhoid and paratyphoid, establishing numerous clinics throughout the area in schools, hospitals and other central points.

PROTECTIVE AND RESTORATIVE PHASE

The Regional Emergency Health Service was formally activated at 9:00 a.m., Sunday, March 29, headquarters being established at the Alaska Native Hospital until removal to Division of Public Health offices became possible. Anchorage operations were set up at the Public Safety Building. Liaison with State and Federal activities was maintained through a State desk in the Civil Defense office, and through this desk most supplies not available through the branch of laboratories and additional personnel were obtained, air transportation arranged, and distant communications accomplished. For a period of two weeks the Division of Public Health suspended routine procedures, all personnel engaging in continuous emergency operations, and both the Alaska Native Health Service and the Arctic Health Research Center furnished not only the officials designated in the plan but also many other employees necessary to continue effective day and night emergency activities. During this time the local health force was augmented by professional persons brought by request from other areas. The U.S. Public Health Service assigned three physicians, two public health nurses and four sanitary engineers; the Division of Public Health, three physicians, twelve public health nurses, three sanitary engineers and seven sanitarians; and the Federal Food and Drug Administration, three inspectors. In addition, many local civilian and military volunteers were requested and gave commendable support.

The Regional Emergency Health Service acted in a supporting role to those communities having a functioning health mobilization capability, providing service to other communities as necessary. With the exception of the special problem of Valdez, all major communities required only the expected assistance with acquisition of supplies and equipment, temporary assignment of special personnel, and furnishing of information and advice. In these communities concentration was upon nursing and sanitation problems, with support also being given to medical care activities.

The need for immunizing large sectors of the population against possible epidemics required that necessary supplies of vaccines, primarily against typhoid and paratyphoid, but also against diphtheria, tetanus, pertussis, smallpox and poliomyelitis be acquired and distributed, as well as biologicals to combat possible hepatitis, measles and botulism. An additional 50,000 doses of typhoid-paratyphoid vaccine with syringes and needles were flown to Anchorage from Juneau, Fairbanks and from the U.S. Public Health Service; following the 38,000 doses given in Anchorage and the 13,000 given in other communities, many reactions were noted, but both proportion and severity of reactions were found to be no greater than was to be expected under normal circumstances. Large amounts of materials for infants, such as diapers and food, were obtained and distributed through nurses and physicians, as were emergency items such as oxygen cylinders, electrocardiographs, blood plasma, first aid and operating room supplies, and household remedies.

Environmental health personnel were primarily concerned with water and food supplies and with waste disposal. After determining the damage to water and sewage facilities, protection of the public from exposure to hazardous conditions required that temporary substitute facilities be provided. Large numbers of water containers, waste receptacles and temporary toilets were distributed, and chlorinators were attached to many public and semi-public water systems. Testing and evaluation of water occupied much of the attention of both environmental health and laboratory branches. There had been widespread damage to food and drug stocks in warehouses, stores, restaurants and homes, and it was necessary to determine suitability of products for consumption, guard damaged stocks against misuse, and properly dispose of condemned goods. As restaurants reopened, close surveillance of operations was maintained by inspection teams, as was also the production and handling of dairy products.

Several hundred refugees were cared for in temporary shelters, and special attention was given to these groups. Several hundred refugees from Kodiak Island, housed in Anchorage for several weeks, were given comprehensive medical and dental care by the agencies routinely responsible. Many Valdez residents were cared for in the Glennallen aera for several weeks, and those from Chenega, in Cordova, but most refugees were able to return to their own homes or were individually integrated into communities within a very few days.

While there were surprisingly few injuries and deaths, a sizable number of persons were reported to be missing. Within a few days after the earthquake information obtained through inquiries to local Civil Defense officials, police, hospitals, welfare agencies and morticians was sufficient to publish an official casualty list which was revised at twelve or twenty-four hour intervals. This activity, along with furnishing information to the public and logistic support, was the responsibility of the branch of administration.

RECONSTRUCTION PHASE

As immediate emergency situations were brought under control, as normal quarters were repaired for re-occupancy, and as no evidence of epidemics or of other major medical problems appeared, a gradual transition toward normal operations permitted release of volunteer and assigned personnel to their usual occupations, the resumption of routine procedures, and eventual return to normal work schedules. A daily conference of health agencies had been instituted for coordination of efforts to cope with the many critical situations arising during the crisis. Planning for permanent correction of damage has indicated the desirability of continuing indefinitely such cooperative group action, and it is expected that additional planning agencies will be incorporated.

Before complete information about villages was received, teams composed of a U.S. Public Health Service physician and Division of Public Health nurse and sanitary engineer visited all village sites in Prince William Sound and on Kodiak Island, offering medical care, providing preventive measures, advising on health precautions, assessing sanitary and welfare conditions, and evaluating damage. With several villages having been badly damaged, evacuated or depopulated, the information gained by these teams furnished the basis upon which the health agencies acted to assure the return of refugees only to repaired, reconstructed or relocated villages which included adequate health provisions. Working in an advisory capacity with those agencies responsible for care of refugees, sanitarians, sanitary engineers, nurses and other health personnel have returned as necessary to village locations and shelters, assisting in arranging satisfactory temporary and permanent facilities. A similar role as advisors and assistants to various agencies and individuals in assessing damage and planning for reconstruction has been played by health personnel in the larger affected communities while continuing to carry out preventive precautions, and plans have been made to continue for the necessary duration such an amplified program.

Throughout the recent period, support of the Emergency Health Service by individuals and and agencies has been almost complete, and it is largely due to this high degree of cooperation that it has been possible to overcome difficulties which have arisen in relation to health, and to expect that reconstructive efforts will result in a health climate superior to that existing at the time of the disaster.

EMERGENCY MEDICAL TREATMENT OF CASUALTIES AT PROVIDENCE HOSPITAL

WILLIAM J. MILLS, M.D.
ANCHORAGE, ALASKA
Chief Orthopedic Section Providence Hospital, Chairman, Emergency Room Committee

This is a summation of the immediate and somewhat less than immediate activity of the Medical Staff at Providence Hospital following the earthquake of 27 March, 1964.

As one might expect from unanticipated disaster, the cessation of the earthquake found physicians dispersed throughout the area. Some were still in their offices or at the hospitals. Others were home or on their way home. Immediately those able to do so went to the area hospitals, usually the hospital nearest. The reaction to the earthquake varied. Some physicians were aware of the extent of damage for they were in the area of destruction, while others, despite the duration and intensity of the tremblor, saw no immediate visible effect of the earth movement.

Providence Hospital itself had sustained obvious disruption of its factilities. Main power supply was off, the elevators were not functioning, and the units requiring main power supply such as the main x-ray area were not functioning.

By six o'clock, approximately 25 minutes after the earthquake had struck, the lobby and emergency room area of Providence Hospital were rapidly filling. Dr. Frederick Hillman arrived at the hospital and as Chief of Surgery and author of the present Disaster Plan, began the organization of the staff in preparation for what appeared to be an overwhelming medical disaster. Sister Barbara Ellen, the Hospital Administrator, and her aides arrived on the scene rapidly and these two and their assistants were soon joined by Dr. Langston, Chief of Staff.

Organization was rapidly developed within the hospital, and as other physicians and medical personnel arrived, assignments were made for care of those already there and for injured victims who had not yet arrived. The success of the care given the patients seen at Providence Hospital was due in large part to Dr. Langston and Dr. Hillman, for having made the immediate decision to direct the admission and routing of casualties, rather than joining personally in the treatment program—the natural function of a physician.

Within the first half hour after the earthquake, the emergency room area was receiving patients. These patients were examined and dispersed to areas of care, either in the emergency rooms and adjacent hallways, or to the fracture room and the surgical suites.

Very early in the evening it became obvious that many of the problems were those involving orthopedic trauma and consequently an open and closed fracture area was instituted. The former was in the surgical suite, the latter in the fracture room section. Soon after the first deluge of patients, the word was passed that Presbyterian Hospital and the U.S. Air Force Hospital were unable to function properly because of earthquake effect. Personnel from both of these hospitals and the U.S. Army Alaska arrived to buttress the Providence effort. This left then, in the area, the Alaska Native Hospital and Providence Hospital for emergency and in-patient care.

The disaster traffic was handled in this fashion—with individual variation on occasion. First, the patients were seen in the admission area (emergency room) where they were examined by a mobile team of physicians and nurses, and assignments made to the hallway for further examination for those less seriously injured, or to the open or closed fracture area, or direct to the acute emergency or surgical area (operating suites) in case of "won't wait" medical or surgical problems. The large recovery room area and the surgical hallway, within the surgical suite, served nicely for observation areas and for recovery room purposes. In the main hallway, directly adjacent to the emergency room, physicians and nurses were re-examining patients who had been sent there with less serious problems, and reevaluating them. This area, because of loss of the elevators and estimated shortage of beds, was made into a ward by placing pallets and mattresses on the floor.

All patients were eventually tagged. From the surgical area or acute care area patients were directed to one of two recovery spaces, where a team of physicians rendered follow-up care and were prepared to offer emergency procedures including tracheostomy. Here an internist, otolaryngologist and ophthalmologist and anesthesiologist were in almost constant attendance, or immediately available. As soon as possible all patients requiring in-patient care were sent to the wards.

During the first 24 hours approximately 200 patients were seen in the surgical area. Records are available on only 108. Many of those not recorded were in the early group seen, were found to have minor injury only and were released to their homes or other areas.

What type of patient was seen?

One of the first arrivals was a patient who had sustained superficial burn, having been in her kitchen during the earthquake. This patient was given no treatment, was sent to the lobby of the hospital to await further care in order to provide immediate care for more seriously injured victims who arrived soon after. At least three patients were labeled DOA, and one patient with traumatic avulsion amputation of a thigh and crush injury to the chest died soon after admission. Soon after, further crush injury victims arrived, one with traumatic amputation of one leg, crush injury, in severe shock, having sustained massive blood loss, with a fracture dislocation of the ankle on the opposite side. This patient was seen in the open fracture area, his amputation completed by skin severance only, dressed and treated by open guillotine method. Two anesthesiologists, a general surgeon, two orthopedic surgeons were in attendance with him the first half hour, the primary problem being that not of his extremity wounds but of blood replacement. This patient was sent to the recovery room where again physicians were in attendance, providing blood, oxygen and performing cut-down procedures and other intubation procedures as necessary. This patient survived his trauma and has since undergone modified re-amputation procedures and reduction of his fracture-dislocation.

Because many more earthquake patients were expected, most wounds seen in the earlier period were treated open, other than minor lacerations that could be cleansed properly and sutured loosely as time was available. From a review of follow-up patients, few in number, but demonstrative of the problem, it is obvious that the age old dictum of debridgement, irrigation and cleansing and open treatment is still effective regardless of the causation of the injury and despite the antibiotic era. No open treatment wounds resulted in deep infection, while one wound, primary repair of a finger amputation, did break down and required guillotine procedure and revision, open care with resolution of the infection after institution of this method of treatment.

The extremity fractures were immobilized in plaster and any manipulative or open procedure required was performed at a much later date. These casts were split or bivalved in the usual fashion and the patient returned then to other areas, to the ward or even discharged home for follow-up care by their own physician. Many patients on admission complained of back or neck pain and others admitted for other cause soon complained of pain in these areas. Of this number some were found to have had compression fractures of either cervical or dorsal-lumbar spine, were held at bedrest or in head halter traction through the emergency period until more definitive care could be rendered. A number of these patients were treated for fracture that was suspected but not definitely demonstrated until x-ray equipment was functioning again after that weekend. There were some cases of closed head injury, one seen very early that had not only injury to the skull but to the cervical spine, compression fracture, but only one craniotomy was required and this was performed during the emergency period for increasing intercranial pressure.

After the first twelve hours it became apparent that although the property damage and physical damage to the Anchorage area was extensive, the loss of life and injury to the inhabitants was minimal considering the intensity of the earthquake. One patient arrived the following day from Whittier, where no medical care was available at the time, and upon removal of her dressings it became obvious from the mottled appearance and brauny induration of the upper arm, the odor and the serosanguineous discharge, that the patient had gas gangrene infection. This was given added confirmation by smear and culture of the organisms in the fluid, and the patient was immediately taken to the operating room where extensive debridement of the tissues was performed. She was transported as soon as possible to the Seattle area where a hyper-baric decompression chamber was available.

All severe open wounds have since been examined, all did well and have in the past few weeks had secondary closing procedures, skin grafts or other care, and will eventually have definitive reconstructive surgery. These were all extremity wounds.

Some comment may be made regarding the philosophy of disaster planning as a result of what has been in our region a considerable destruction of property, but fortunately minimal loss of life and surprisingly little physical injury to the inhabitants. It is apparent first of all that most hospital staffs have all the necessary professional capability for adequate disaster care. Most physicians in Alaska, are familiar with problems of individual or small group trauma. The care of large group trauma, under most circumstances, becomes then only a matter of economy of organization. The individual disasters familiar to so many of us are multiplied by any larger factor and care thus instituted. With no problem the entire Providence staff and their help from elsewhere rallied to what might have been an extensive medical disaster, and disposed very rapidly of the patient problems presented. With adequate knowledge in all specialties as well as general practice represented, this program required only leadership and that was immediately available by the Chief of Surgery and the Chief of Staff and the Hospital Administrator.

Several comments might be made regarding initial care. Since disaster is commonplace from one cause or another, a method of identification and tagging should be readily available at all times in the hospital. This should include space for diagnosis or differential diagnosis and for immediate record of drug or immunizations given or required. Spacing might be provided on the tags for routing direction. The immediate emergency room or receiving center where the patients are first seen should include physicians knowledgeable regarding all fields of medicine, and here those in general practice did nicely. Floating surgical specialists may be available in this area and certainly this is a region that should include those who are not only capable of doing a tracheostomy or other intubation emergency procedure, but are psychologically suited and are willing as well as able to perform those procedures.

The recovery rooms and emergency suites, including open and closed fracture areas should include also a physician willing and prepared to do emergency procedures as necessary.

We found during this brief period that the anesthesiologist and the pediatrician were particularly apt and helpful since these individuals are accustomed to doing intravenous work in difficult circumstances.

There is a place in disaster planning for everyone, regardless of his interest or specialty, and future planning could well include plans for all of these individuals, not only as individuals but as groups according to their interest or specialty. This plan must be broad enough in scope to consider however that the physicians themselves may not be able to attend the hospitals of their choice or any hospital still remaining, and in fact might well be victims of a disaster.

There is never a question obviously as to when a disaster begins. It is less obvious however, when the disaster period is terminated and routine procedures and care should be instituted. After the first 24 hours at Providence Hospital the physicians in attendance were divided into shifts and since many of the injuries were orthopedic trauma, the orthopedic section itself elected to place two men on eight hour shifts the second 24 hours followed by one individual covering eight hour shifts for the next 24 hours.

This provided constant evaluation and surveillance of the patients admitted, and in effect permitted these patients to be seen at least eight times daily and during the night. With the help of physicians stationed on the floors the follow-up care was rendered much easier, and further diagnosis of unrecognized injuries made. This system of follow-up care permitted physicians who had treated the patients under the emergency system an opportunity to see these patients afterwards and provided continuity of care between those rendering care in the emergency area and those who were following and developing the treatment on the floors.

As the emergency period tapered off, a final problem was present, that of providing long-term or definitive care as well as definitive physicians for care for these earthquake victims.

The patient cannot be left under general care with conflicting opinions and orders less a state of anarchy develop. This refers to medical anarchy, probably as disruptive of physician-patient morale as any other type. Consequently the Chief of Staff with the Director of Nurses visited each patient, and either the patient or family (the Chief of Staff, having determined the emergency to be over) determined who they wished for a physician and were then transferred to his service. From this point on, this by the fourth day, the hospital was back in routine function, licking its own wounds but performing adequately.

QUAKE RUMBLINGS FROM ALASKA NATIVE HOSPITAL

WALTER JOHNSON, M.D.

U.S.P.H.S. Hospital, Anchorage, Alaska

Although the bluff behind the Alaska Native Hospital yielded to the quake and gave way in places, the building stood. Patients on the fifth floor found their beds tossed across the room but no patient was seriously injured. They took this, as they have many other disasters, with their usual equanimity. Thousands of medical charts and x-ray folders were shaken from their files and the file cabinets turned over on them. The x-ray panels were wrenched from the walls. Hundreds of bottles of drugs in the pharmacy danced off their shelves and smashed on the floor. In the store-room stacks of cases of food and supplies were toppled.

Both patients and staff owe a great debt to Mr. Laurence P. Johnston, architect of Evanston, Illinois, who designed the building. The sprawling building was erected as four distinct units. During the quake each wing rolled separately, the building dividing neatly at the "crumble joints" as it was designed to do. Without these the building would certainly have been torn apart in a haphazard manner. Two steam pipes were sheared off where they passed through the main beams at the "quake joint." Several days were required to repair this and other breaks in the steam pipes. During this time the building cooled slowly. Space heaters were obtained through Civil Defense and these kept pediatric wards acceptably warm. Fur parkas, wool slacks, and mukluks became the uniform of the day for patients, doctors, and nurses. Treatment for patients suffered no interruption.

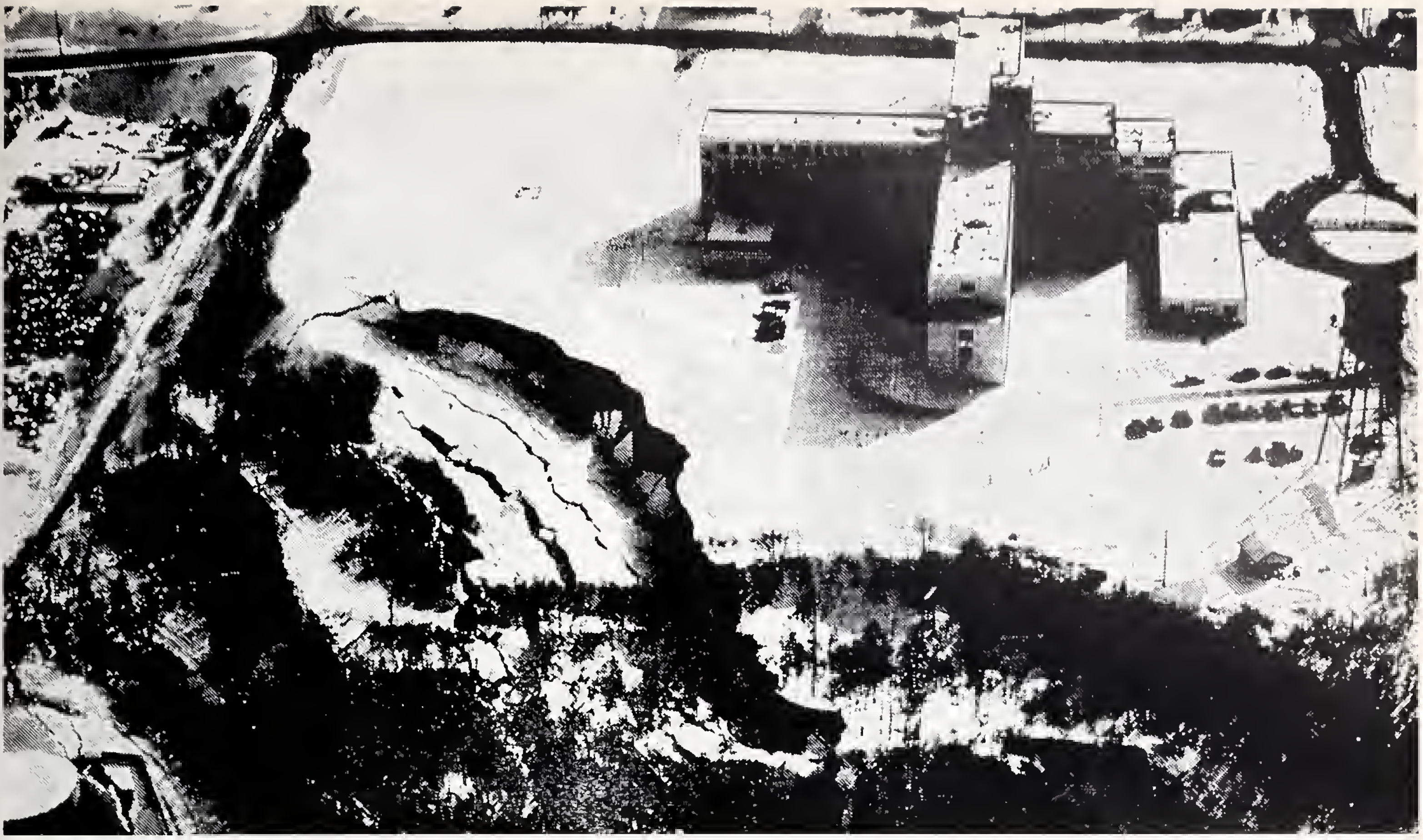
Medical teams including Fairbanks and local physicians were organized to give around-the-clock coverage and the staff readied itself to accept large numbers of casualties. A triage area, and surgical treatment areas were set up in the lobby and outpatient department. A temporary morgue was set up in the hospital garage. The number of injuries seen and treated were amazingly small and the "morgue," which one would have predicted would be filled, was not needed.

As it became clear that the major medical needs in the area would not be the management of a large number of casualties but would be the prevention of disaster-related epidemics, the staff of this hospital volunteered its facilities and manpower to the office of Emergency Health Service. One wing of the area office building was turned over to that organization and other space was made available for mass typhoid immunization clinics. Physicians, nurses, nutritionists, sanitary engineers, sanitarians, and secretaries were detailed to the Emergency Health Service as needed.

A number of the staff lost their homes, and Anchorage people living nearby came to the hospital for shelter. Mattresses and bedding were put down in lobbies and conference rooms so that many families were accommodated until they could find more suitable shelter for themselves. The staff kitchen supplied meals to all refugee families through Civil Defense arrangements.

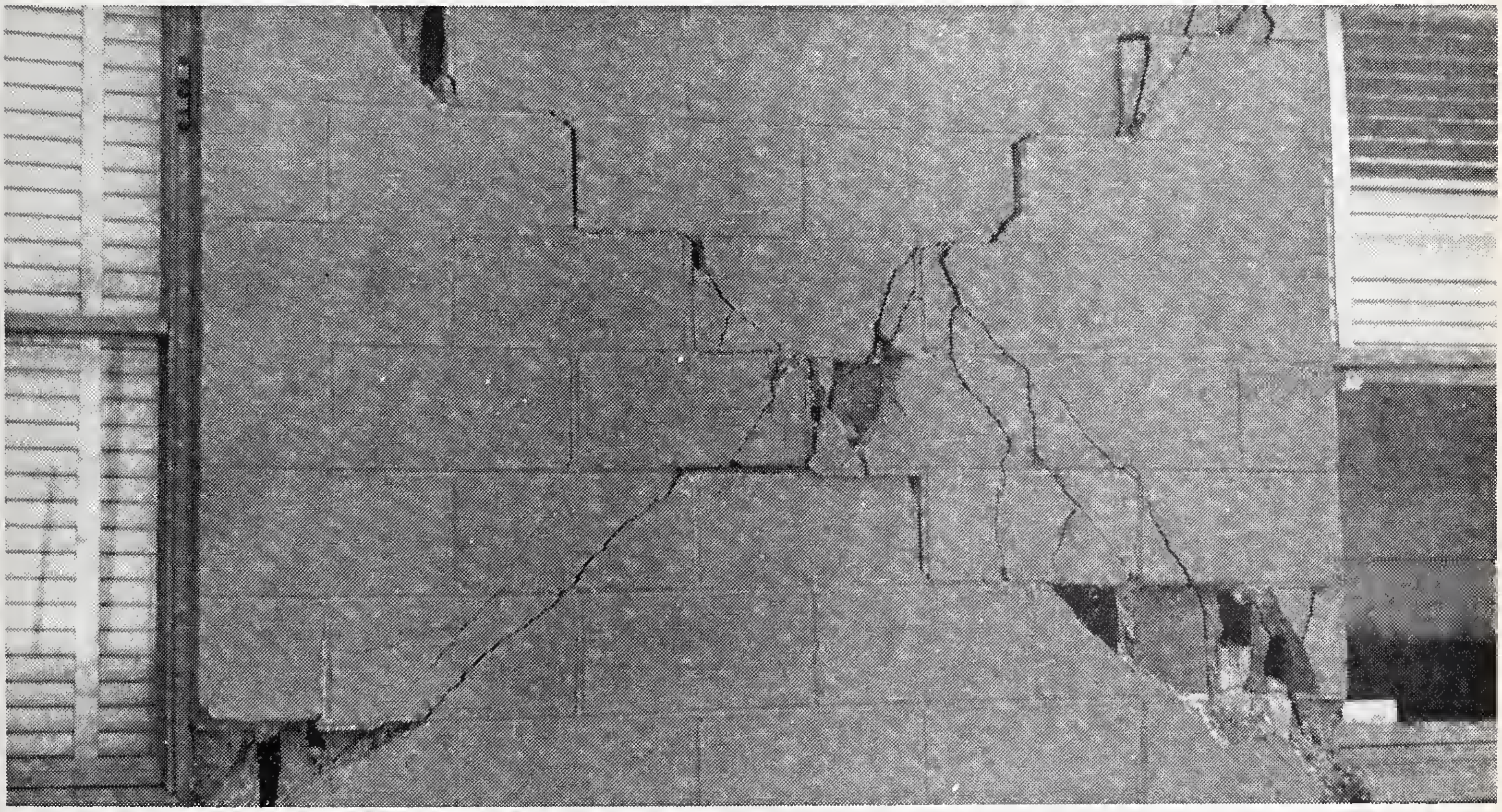
After the quake and seismic waves had destroyed the villages of Old Harbor and Kaguyak, the entire population was evacuated to the Airport Heights School in Anchorage. This was the first time they had all been near a medical center and full advantage was taken of the situation. All were tuberculin tested and given chest x-rays. Through a combined Alaska Department of Health and Public Health Service effort the x-rays were processed and read immediately. Several patients were admitted for evaluation and a number placed on chemotherapy. Dental, eye, and orthopedic problems were treated. A number of children were admitted for tonsillectomy and adenoidectomy. Daily sick call at the school and many visits to the outpatient clinic gave an opportunity to see and treat the many miscellaneous medical problems.

Meanwhile, all records and x-rays have been retrieved from the jumble on the floor, have been sorted and placed back in temporary files. Order has been restored in the pharmacy and the store-rooms. Repairs on the building are underway. None of our staff was lost and their enthusiasm to carry out the mission of the Service in Alaska was unshaken.



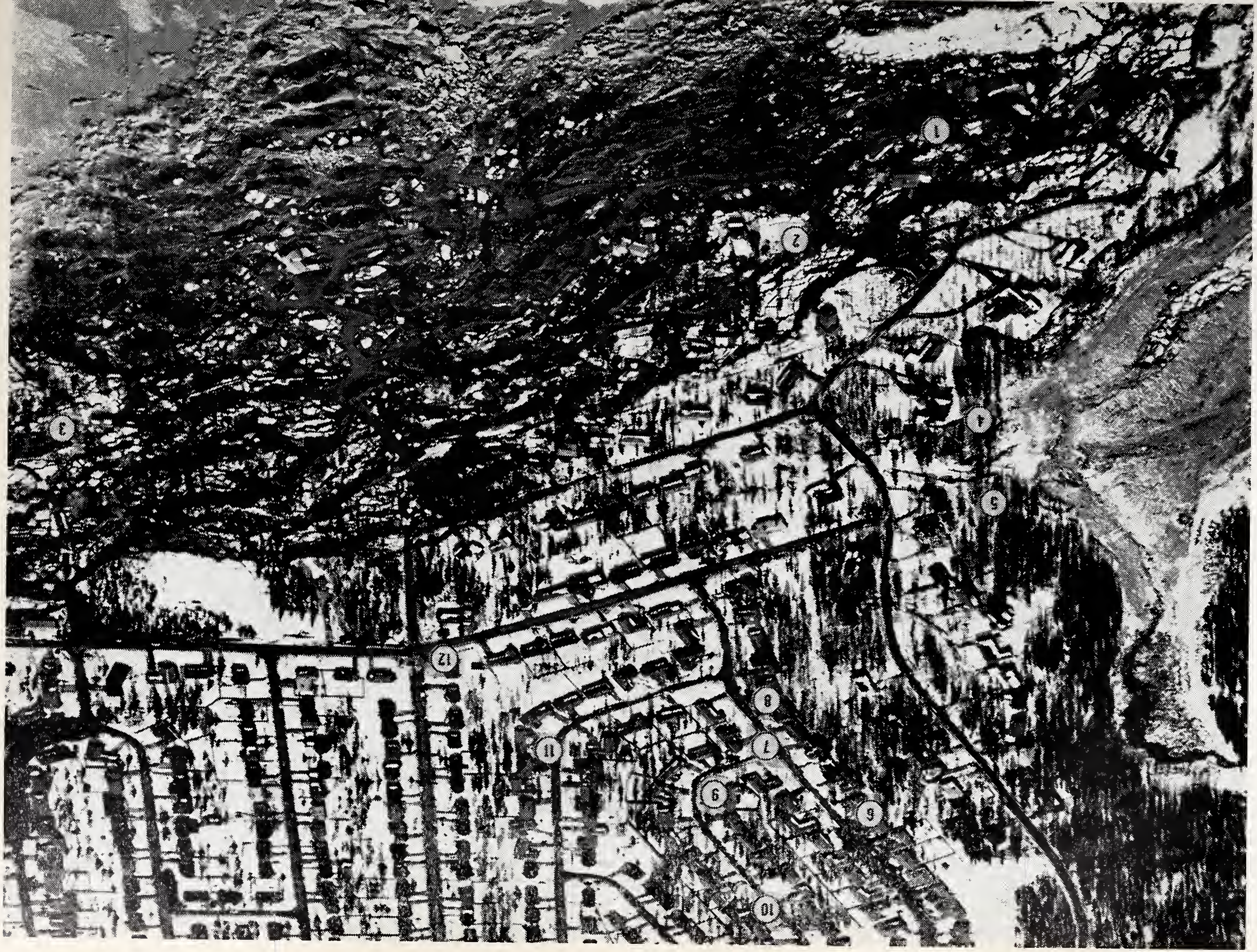
U. S. Army Mohawk Photo

Alaska Native Hospital at Anchorage and First Avenue Slide following March 27, 1964 earthquake.



United States Air Force Photo

A typical wall of USAF Hospital Elmendorf following the Good Friday Eearthquake. Total damage is estimated at approximately $2,600,000. Evacuation of all patients was accomplished in eighteen minutes and a temporary 200-bed hospital utilizing nearby barracks was made operational in thirty-five minutes. Normal hospital operations were reestablished on 6 April 1964.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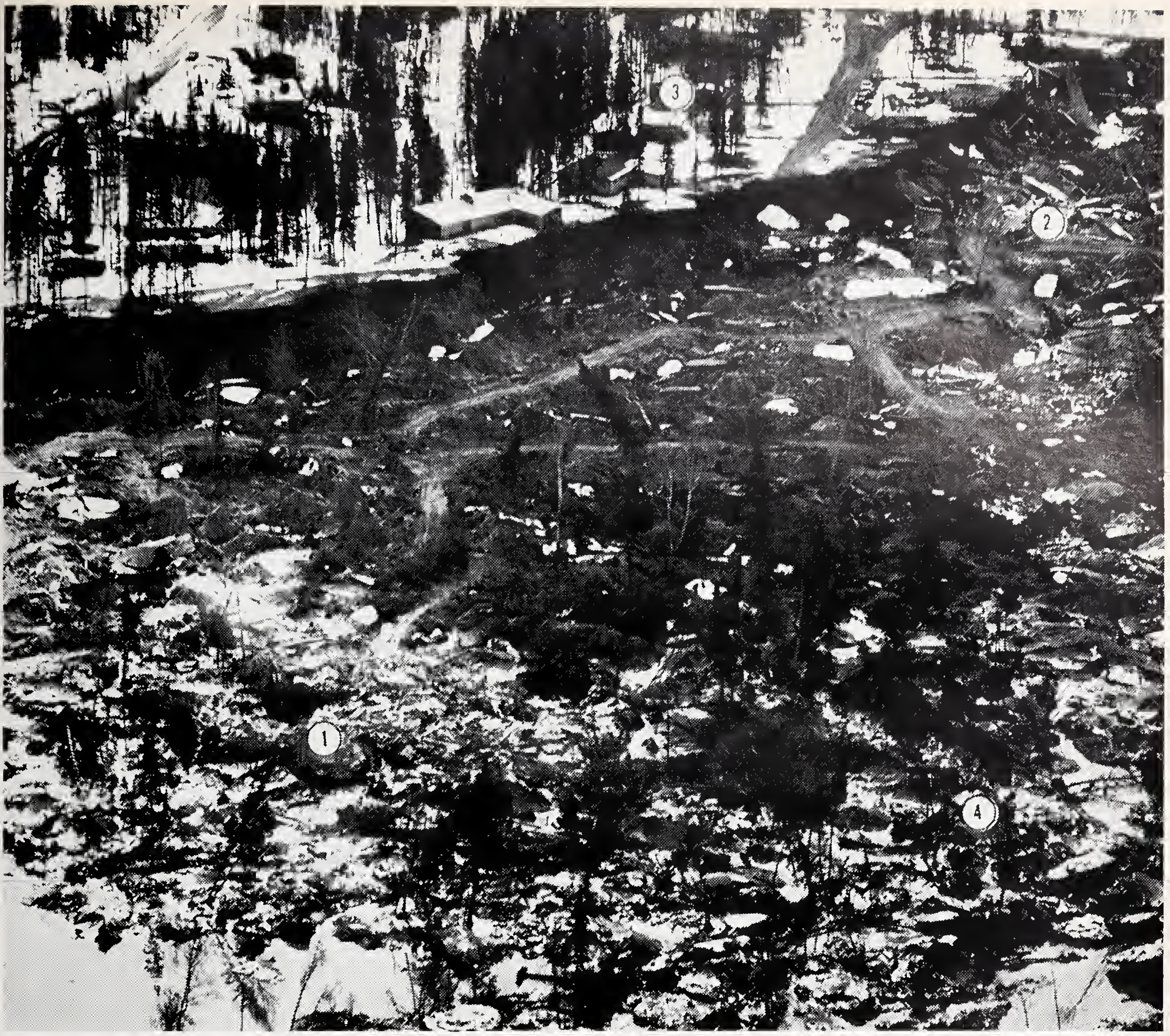


Mac's Foto

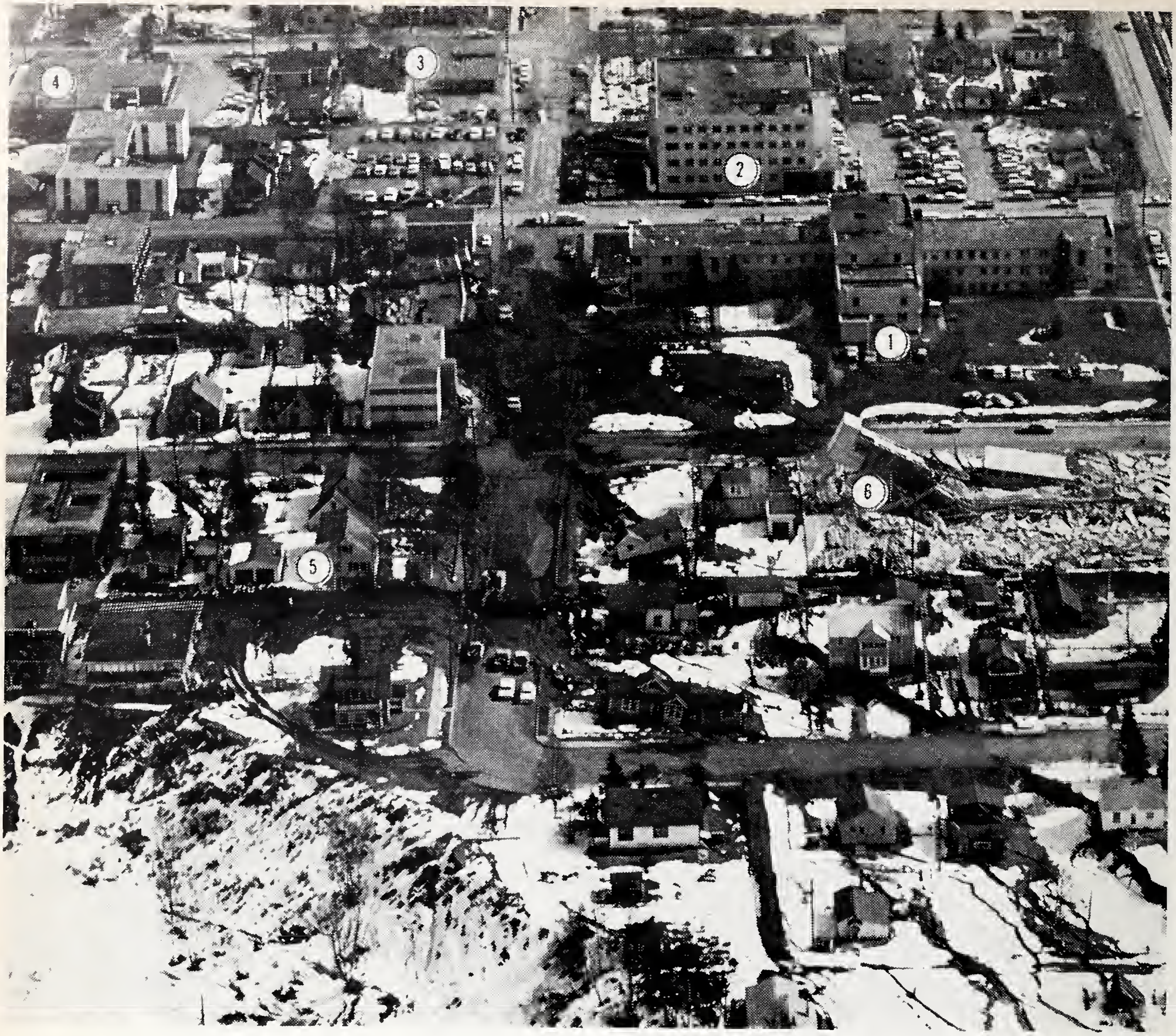
TELEQUANA BLUFF AREA, ANCHORAGE **(Above)**

1. Area of the residence of Dr. Perry Mead near which his sons Perry, 12 and Merrill, 2 were last seen.
2. Residence of Dr. Richard Sutherland
3. Residence of Drs. Theodore and Rosalie Shohl
4. Lot upon which the Drs. Shohl planned to build in the summer

TURNAGAIN BLUFF AREA, ANCHORAGE **(Facing)**

1. Residence of Dr. Asa Martin
2. Residence of Drs. Robert and Helen Whaley
3. General area of the residence of Dr. William Caughran
4. Residence of Dr. Jack Sedwick
5. Residence of Dr. Francis Phillips
6. Residence of Dr. Robert Wilkins
7. Residence of Dr. Charles St. John
8. Residence of Dr. Royce Morgan
9. Residence of Dr. J. Ray Langdon
10. Residence of Dr. Mahlon Shoff
11. Residence of Dr. Don Val Langston
12. Residence of Dr. John Pennington

Mac's Foto



Mac's Foto

PORTION OF THE L STREET SLIDE, ANCHORAGE

1. St. Mary's Residence
2. Medical Center Building, including Presbyterian Community Hospital, the Doctor's Clinic, and the private offices of Drs. Koeniger, Renn, Shoff, Shelton, Mead, J. Tower, H. Whaley, and Zartman.
3. Office of Drs. Mills and Kettelkamp
4. Anchorage Medical and Surgical Clinic
5. Residence of Dr. Rodman Wilson
6. Four Seasons apartment building
   (This photograph was taken at least a week following the earthquake and the streets have been filled in places where they were crossed by the slide)

Editorial Page . . .

GOOD FRIDAY — IN RETROSPECT

This issue of ALASKA MEDICINE has been designed to present the medical and public health panorama of the Good Friday earthquake and tidal waves in South Central Alaska both verbally and pictorially. One psychological reaction to a natural disaster of this magnitude that Drs. Langdon and Parker have not described in their article, but which is prevalent, is the temptation to moralize upon the happenings and come to some conclusions regarding them. Please forgive us if we here participate in this form of rationalization and present the following conclusions:

1) **We were almost unbelievably lucky both in the paucity of casaulties requiring treatment and in the miraculous sparing of the medical facilities.** As the pictures in this issue will illustrate, very slight changes in the configuration of the slide areas might have placed the Alaska Native Service Hospital in a position similar to that of the Government Hill School—split in two with one half at the bottom of a 50 foot cliff—or might have rendered the Presbyterian Hospital building or St. Mary's Residence a mass of rubble like the Four Seasons Apartment across the street. A half block shift in the L Street Slide would have wiped out not only two hospitals but the offices of half of the physicians in Anchorage.

2) **We were reasonably well prepared for the emergency and acted creditably when it occurred.** Enough key people had been involved over the last ten years in the frustrating task of evolving Civil Defense plans that alternated between the evacuation and the "stay put" philosophies that at least their thinking, if not their actual footsteps, were directed into the proper channels allowing them to meet the situation as it presented itself confidently and effectively. The reactions of the people in general were all that could be hoped for in a young and vigorous but mature population, intent upon self preservation but at the same time aware of the necessity of combined effort for the common good. The man-made complications of panic, fire, looting, and pestilence did not compound the insult dealt by nature. Although it turned out that the earthquake and tidal waves did not result in a major medical disaster, they did provide a learning situation for both the civilian and military populations that was far more effective in its realism than any maneuver could hope to be. As a result those who participated will be better prepared to analyze and meet Civil Defense emergencies in the future.

However, while we take a deep sigh of relief and pat ourselves lightly on the back, we must remember that:

3) **We are presented with a tremendous future responsibility of planning and building in the fields of medicine and public health.** Not only must we replace or rebuild facilities like Harborview Nursing Home for mentally defective adults which was destroyed at Valdez and repair the millions of dollars of damages to the health facilities that survived, but we must also face needs that existed prior to Friday, March 27, 1964. In this issue, Dr. Kettelkamp points out the inadequacies of the Crippled Childrens' Program and Dr. Isaak reaffirms the need for a hospital in the rapidly growing Kenai-Soldotna area to mention only a few. Not only must many needs be met, but they must be met by a State that has lost over 50 percent of its tax base and by individuals whose energies have been taxed in many cases by serious personal and financial losses and by the nagging uncertainties of having valuable properties sitting damaged upon shifting soils.

Therefore at the forthcoming meeting of the Alaska State Medical Association, let us dedicate ourselves to the great task remaining before us—the task of delineating our needs on a statewide level and analyzing the most effective, expedient, and inexpensive ways of meeting them.

Elizabeth A. Tower, M.D.

KENAI-SOLDOTNA HOSPITAL

Fortunately our damage in the Kenai-Soldotna area was slight. As far as I am concerned this devastation has pointed out more clearly than ever the need for a hospital here. With the highways to Anchorage and Seward being out for several weeks, one airport in Anchorage unusable for several days and the same situation in Seward due to the tidal wave, we would have been in a real fix if we had had any number of casualties.

Unfortunately, I'm afraid the catastrophe will delay our hospital project for several months or more—only time will tell. It all depends on how important other people feel this facility is.

Paul G. Isaak, M.D.

ALASKA CRIPPLED CHILDREN'S PROGRAM

"The History of the Orthopedic Program for the State of Alaska" by Dr. Philip Moore was published in the first issue of ALASKA MEDICINE, March, 1959. This history concluded with the following paragraph.

"Acting as a consultant, I have viewed with considerable alarm the decrease in orthopedic field clinics and organized hospital treatment. The orthopedic residency program has been discontinued, and there has been no replacement of a full-time orthopedist. Our master file at Mt. Edgecumbe containing essential data on approximately 7,000 orthopedic cases is now about two years behind. The data arriving in field and hospital reports will not be replaceable unless definitive steps are taken to re-organize the program, its future is in doubt. This program should be unified and centrally directed without regard to race. Competent orthopedists should direct the orthopedic care. In my opinion, the need for a continuing program is urgent. Without such a program we may again find an increasing number of people crippled and dependent on our tax funds for support."

Dr. Moore's concern and opinions were not heeded and the Crippled Children's Program continued its decline.

In May, 1962, Dr. William J. Mills, Jr., as president of the Alaska State Medical Society appointed a Committee of Public Health with special reference to the Crippled Children's Program. At the Alaska State Medical meeting in Anchorage in May of 1963 the appointed committee presented its report. The following recommendations were made:

1. That an effective statewide registry of crippled and handicapped children be implemented.
2. That a medical advisory board to the Maternal and Child Health and Crippled Children's Services branch of the Alaska Department of Health be formed.
3. Continuation of the Child Study Center.
4. That orthopedic field clinics be re-instituted.
5. That legislative action be taken to provide funds to operate an adequate Crippled Children's program.

This report was accepted by the Alaska State Medical Society and the committee reappointed for this present year.

The Child Study Center, a federal grant, has been continued. An application for a grant for the multiple neurologically handicapped child is being made. There is a functioning re-evaluation board for priority of ENT patients, however, this past year all of the clinics have been by U.S.P.H.S. personnel.

There still is no statewide registry, no official medical advisory board, and no formal orthopedic field clinics. The state legislature and the governor have cut rather than increased the budget for the Department of Health and Welfare. The care of Alaskans, particularly the crippled and handicapped child, should have top priority with our legislators. The registry and field clinics could have been a reality with adequate appropriations. It is now time to re-examine our values and obligations.

The earthquake of Good Friday, 1964, compounded Alaska's problems but demonstrated the Alaskan's ability to help each other in time of disaster. If the personal disasters of the crippled child are to be met this Alaskan spirit must continue.

The legislators must not become so involved in the reconstruction of material things that the reconstruction of the crippled Alaskan child is forgotten. Appropriations for Maternal and Child Health and the Crippled Children's Service must be increased even in these trying times. The cooperation demonstrated between the Alaska Department of Health and the U.S. Public Health Service during the recent emergency must be continued for the care of the crippled child. There is no place for bureaucratic empires. The medical advisory board must have official status. The physicians on this board as recommended previously are the working nucleus of both organizations and as an official organ can help assure the co-ordination of all efforts. The registry must become a reality or the crippled child will continue to be lost in our inlets, tundra and forests.

In a few minutes after 5:36 p.m., Good Friday, 1964, Alaska was in economic ruin. She had one thing left, her greatest resource—her people. People are what this is all about and crippled children are people.

Whose responsibility?—Our responsibility; as individuals; as a state; Alaska's responsibility.

Will the new Alaska meet this responsibility?

Donald B. Kettelkamp, M.D.

COMMENTS ON SEWARD EARTHQUAKE AND TIDAL WAVE

J. B. DEISHER, M.D.
SEWARD, ALASKA

The occurrence of a severe earthquake beneath the bottom of Prince William Sound at approximately 5:37 P.M. on 3/27/64 provided severe shock waves to the entire Southcentral portion of Alaska for a period of approximately eight minutes. The shocks were felt with considerable severity in the City of Seward and resulted immediately in rupture of certain oil tanks or lines at the Standard Oil storage installation there with spreading of oil fires within the tank farm and along the surface of the sea at shoreline and along the Alaska Railroad tracks through a series of tank cars to a Texaco tank farm approximately one-half mile distant. The entire shoreline of the city was markedly modified, much of it crumbling away and falling beneath the surface of Resurrection Bay. The quake itself was followed by two severe tidal waves, the first estimated to be about 25 feet in height and the second estimated at 40 feet. A tanker was transferring fuel at the Standard Oil Dock at the time of the earthquake. The dock disappeared into the water and the tanker was lifted up and carried inland from the dock by the first tidal wave, which snapped all hausers and pipelines and was then submerged by the second tidal wave and come up from beneath the surface of the sea according to one description and then moved under its own power out into the bay itself.

The surface of the earth is described as having rolled in waves as though it were a fluid. Many of the people in small buildings felt as though they were riding an airplane in extremely bumpy air or a ship over a very rough sea. Cracks up to two feet in width and 13 feet in depth appeared in the surface of the earth in various places and it is estimated that the shoreline of Resurrection Bay has dropped approximately eight to 10 feet so that the tides are now 8 to 10 feet higher.

PREPARATION FOR DISASTER. For the past five years the Seward Area has been regarded as the SAFEHAVEN area for the U.S. Air Force installation in the Anchorage area. It was planned that in the event of a serious threat of atomic hostilities the military dependents of Air Force personnel (approximately 25,000 persons) would be dispersed to the Seward area (population 2000-2500). A similar number of civilians not connected with the military were to be dispersed in the remainder of the Kenai Peninsula. The Civil Defense organization in Seward in conjunction with Air Force planners visualized the institution of a 600-bed hospital facility using a pavilion system in the Seward area. Materials for this purpose were stored in the Seward area including four 50-bed Air Force hospitals and a 200-bed incomplete Civil Defense hospital. Plans were laid to expand the capacity of the Seward General Hospital and the Wesleyan Hospital for Chronic Disease to 100-200. Adequate rations for the personnel to be displaced to this area were stored hereabouts. The City Manager of Seward was designated as the Civil Defense director for the entire eastern half of the Kenai Peninsula, department Civil Defense heads were designated, and written plans developed. Householders had been instructed periodically on the construction and stocking of individual fall-out shelters.

HOW DID IT WORK? When the earthquake struck there happened to be no ships tied up at the wharf of the Alaska Railroad facility in Seward. Work had been completed and the longshoremen had all returned to their homes There was a tanker tied up at the Standard Oil Dock but only a few personnel were on the dock. The City Manager and Mayor of Seward were both in Anchorage. A common saying in Seward referring to the disaster of fire has been, "when Standard Oil goes, the town will go." As soon as the earth had become relatively tranquil the plume of black smoke issuing from the Standard Oil installation caused most of the people in the lower levels of Seward to jump into their automobiles and depart from the city. If they had not done so, fearing fire, many of the people in the lower levels of Seward would have been drowned in the subsequent tidal waves. As it was, they reached high ground sufficiently far out of Seward that they escaped innundation by the waves which picked up ships up to 100 feet long and moved them up to one-quarter of a mile inland. Only one body was recovered which was presumed to have drowned.

Physicians, nurses, nurses aides and other personnel associated with the hospital appeared at the hospital within a few minutes after the disaster in gratifying numbers. We fully expected to see within a few minutes a stream of burned and injured people which would overwhelm us. Approximately 10 to 15 minutes after the second tidal wave a single body was brought in. It was that of a railroad worker who had suffered a heart attack. He was dead on arrival at the hospital. For two or three days these were all of the known dead. Subsequently the body of a man was found having been crushed between two twisted railroad rails. Ten days after the tragedy the total of deaths from the earthquake and tidal waves remains at three. Ten are missing and presumed dead.

Following the established pattern for Civil Defense, men were sent to the basement of the hospital to obtain stored cots and set one up in each of our two-bed rooms, extending the hospital's capacity by 50 per cent. Other cots were set up in the halls. Many refugees appeared who were not actual medical or hospital patients but had no other place to go and came to the hospital for sanctuary. Many of these people were bedded down in empty rooms and in the halls during the first night since we had such a small load of actual medical problems from this disaster. With the loss of power, water and sewer the hospital turned out to be the only place with adequate electricity for setting up any sort of communications center or Civil Defense headquarters. At the suggestion of a physician the councilmen were brought together in a meeting in the basement of the hospital to set up a semblance of government and establish a plan of approach to the serious problems which it was recognized would face the community. A temporary mayor was appointed from amongst the councilmen in the community and initial steps were taken to house and feed people who remained in town. The fact that so many people had left town eased the problem greatly during that first night. Several people who were weak and infirm but capable of managing independent existence in their home environment were brought to the hospital when they were required to leave their homes because they could not manage adequately in a transient state. This was abused only very slightly. Within the next few days the Wesleyan Hospital for Chronic Diseases was persuaded to create space to house these people so that the facilities of the Seward General Hospital remained open for the acute medical problems.

ACTUAL MEDICAL PROBLEMS. A seaman standing on the Standard Oil Dock when the tidal wave hit, was swept under water and finally thrown back on the deck of the Standard Oil tanker just before it moved out into the center of the bay. Somewhere in the course of his voyage from the dock to the deck of the ship he fractured his fibula and received a laceration of the scalp and the back of the right hand. None of these were serious. One adolescent girl was brought in with a burn of her foot which she received from hot water as she was getting out of the bath tub to leave her home as a result of this disaster. One case of frostbite of the feet was brought in next day. This was an elderly gentleman who had been swept into a tree-top and after spending four or five hours standing with wet shoes and sox on a limb of the tree, had been rescued by others and brought in. Several severe contusions were seen in men who were actually washed about by the tidal wave and thrown against large floating timbers. The seaman with the fractured leg was not brought to the hospital for approximately two days because all facilities for mooring the ship had been destroyed. He was finally lightered ashore, and with the man with the frost-bitten feet, was evacuated by Army air transport. These were the extent of our injuries aside from several bruises and very minor lacerations and puncture wounds of the soles of the feet due to stepping on nails protruding from boards.

An outbreak of "influenza" which clinically seemed to correspond to the descriptions of Coxsackie Type A-9 virus infection, had begun prior to the disaster and the incidence was potentiated by the removal of people from their homes and the intimate intermingling of usually unrelated families combined with the stress conditions, both physical and emotional. There were relatively few cases of "going to pieces" and these usually could be treated quite easily with "glue" pills, Thorazine, 25 mgm., q.i.d About the third day timed-release preparations of Meprobamate were passed out on a single dose basis to permit relaxation and sleep in people who had become quite wound up. There were no obstetrical deliveries during the week subsequent to the disaster. There were no major surgical procedures subsequent to the disaster. Exacerbation of previous cardiac disabilities was noted, especially in relation to the influenza which of itself constituted by far the largest problem. Two children became severely dehydrated as a result of vomiting and diarrhea and required hospitalization and stringent measures to relieve their conditions.

PUBLIC HEALTH MEASURES. Typhoid inoculations were begun on the third day after the disaster with the assistance of nurses and others in the community and an immunization clinic was repeated on the fifth day with a total of 2470 injections of typhoid vaccine. The intradermal dose of 0.1 cc. was used and the number of marked lymphangitic reactions was startling, probably in the neighborhood of one in forty or fifty. One small abcess was seen at the site of inoculation approximately one week later.

Without a City Health Officer or a Sanitarian in the community, the supervision of shelters, feeding places, and water supply, fell on the shoulders of the Civil Defense Medical Officer. With coaching and coaxing it was possible to get the sleeping and feeding arrangements to come up to at least minimum standards of sanitation to prevent an outbreak of serious illness. Within hours after the disaster the first issue of a mimeographed bulletin to the citizens of the community was put out giving directions for the sterilization of water with Clorox or other chlorine solution, and an order was sent out for water treatment tablets. Water was obtained by cutting a hole through five feet of ice into the surface of a fresh water lake within the confines of the community from which water was pumped with a Civil Defense jeep pumper. Some people obtained water from a creek nearby the community. It was impossible to use melted snow because the greasy soot of the oil fires lay like a pall over the entire area.

Because the condition of the sewers was presumed to be completely unutilizable, the citizens were advised to set up a "honey bucket" system so that the solid excreta were placed in a container outside the door of the residence and a truck went through all the streets of the community once a day picking up refuse from these containers. Community "half-can" latrines were set up in strategic areas. Final accurate check-out of all the water and sewer pipes within the community will not be possible until after the frost is gone from the ground. Up until that time presumably the pipes will be held intact by the frozen ground. The citizenry was advised to continue sterilization of their water until cultures had been obtained and it was clear that there was residual chlorine at the farthest end of the pipes from the city water supply where the water is chlorinated.

BACK TO NORMAL. Within ten days after the earthquake hit, the radio transceivers were long gone from the hospital administration office, the hospital census had subsided to nearly normal, and the routine shifts of nurses were in operation in the usual manner. Almost all of the citizens were back in individual residences although not always in their own original residence. Water, sewers, telephones and electric power were functioning, and the difficult, dreary task of rebuilding the community had begun.

The American Red Cross representatives arrived in the community within three or four days after the disaster and were delegated the entire problem of feeding, housing, and family maintenance. The Corps of Engineers was brought up within the first week and they assumed responsibility for cleaning up the town and reconstructing its public utilities as required. Communications with the outside world was tenuous but functioning by phone and telegraph service.

COMMENTS. This disaster showed three psychological phases: (1) The horrible, (2) The challenging-exciting (hopped-up), and (3) The hard, drudgery phase. The first phase is one of instinctive reactions to a terrifying predicament. During this phase there is little clear cerebration and reasoning, but the actions and reactions are for the most part quite effective in escape from danger if the danger has any escape. The effectiveness is increased if even part of the emergency had been forseen and plans laid to escape it or combat it. This is the phase in which occasional irrational moves are made such as saving a child's toy instead of a blanket or at the risk of a life. After the emergency is over there are frequent large gaps in the memory of most people as to when, and in what sequence events occurred. This phase lasts about 48 hours, or through the second night.

On the morning after the first night the second exciting, challenging phase begins as the citizens begin the assessment of their situation and begin to find new solutions for the ordinary problems of living moved out of their usual context. Whatever disaster plans have been made are now given a test in actual function. Corrections and modifications are made. As the solutions to simpler immediate problems begin to work more complex problems appear and solutions are found. Personnel, hopped up by endogenous adrenalin, work amazing hours with little or no sleep. This period lasts until about the fourth day when the fading excitement is outweighed by the fatigue. It is at this point that tempers begin to snap, and harm may be done the common effort. A discussion of the facts of this emotional change at this time is very useful in helping everyone to recognize his tiredness and temper. Frequently the chief administrators of the disaster program require a mild tranquilizer (such as Thorazine, 25 mgm., once or twice a day) about the third day to handle a mild emotional irritability and to help them unwind enough to get to sleep for their much needed rest. Supervisors are wise to insist on sleep periodically and in shifts for their personnel before fatigue and exposure lead to disease. During this period, although it is not supposed to work, the use of large doses of antibiotics such as a combination of 1,200,000 units of penicillin and chloromycetin 500 mgm. for two-three doses, seems to abort incipient upper respiratory infections with good consistent frequency.

The third phase of reconstruction is the long hard road back. It starts when a nearly normal living schedule has been resumed by 80 to 90 percent of the population. It lasts until the way of life returns to what is regarded as normal. The physicians role is to provide as sound and stable a position for his patients to rely on as he can. He can assist the authorities by forseeing breaks in the morale of the people and keeping his "public-health-eye" open at all times. Through the preceding periods as well as this one, a sense of humor and an abiding faith are often the best medicine he has.

SUMMARY. After a devastating earthquake, fire, and tidal wave, which removed the shoreline of the city of Seward, the medical problems were astonishingly small and largely related to Public Health and sanitation. The minimal number of actual injuries related to this disaster allowed the citizens of the community to continue to manage the medical problems without help from outside other than the importation of a sanitarian, a pharmacist, a Public Health laboratory technician, and a relief Public Health Nurse, after the first week. The training provided by participation in Civil Defense planning was extremely helpful in guiding the preparations for the health of the people in the medical sphere. In spite of the time-consumption and the faint self-conscious feeling of foolishness involved in Civil Defense and disaster training, one who has been through the ordeal of planning and executing plans for the handling of mass casualties can only recommend that everyone who might be called on in this regard, have some experience in "mock-up" and "walk-through" sessions just as we have fire drills for the children in school.

DIRECTORY OF DISPLACED DOCTORS

DR. A. S. WALKOWSKI	825 L Street (Temporary)
DR. C. E. CHENOWETH	825 L Street (Temporary)
DR. MILO FRITZ	Old Providence Office Building 800 L Street (Formerly St. Mary's Residence)

REPORT FOR KODIAK

J. BRUCE KEERS, M.D.

KODIAK, ALASKA

When the quake started Friday, March 27, I had just driven over in the VW from the office to the hospital and had just pulled on the emergency brake. It took perhaps ten or fifteen seconds for me to realize that the gentle bouncing movement of the car was due to something external, and I then opened the door and got out. The very next moment the movement became so violent that I was forced to hold the luggage rack on top of the car with one hand in order to remain standing. I remained there until the quake subsided, some three minutes later. During this time, the rippling and rumbling of some nearby Standard Oil storage tanks, the whipping back and forth of the hospital flag pole, not to mention the violent motion of the ground on which I stood, were as awe inspiring as anything I've ever experienced.

After spending ten minutes or so reassuring the patients and checking the hospital for cracks or other signs of damage, and another similar period of time for a quick trip home to the family, I checked the downtown business section and small boat harbor area. The only visible damage was some cracked or broken windows. The canned goods at the supermarket, of course, were all over the floor. Otherwise, it was just like any sunny, calm spring day down town.

Then the ocean began to rise. At first we all began to notice the water in the small boat harbor getting higher and higher, until it began to overflow onto the adjoining parking area. At this point, we all began to clear out of the downtown area. This first wave rose until it almost reached the main street at its center, and flooded the lower end, and floated a few of the houses around a bit, then gradually receded. This was about 7 p.m. The tide was then low, so this probably represented a ten or fifteen foot rise. I was already back at the hospital, and we were all waiting for further reports.

The hospital, as some of you know, stands on a solid rock bluff overlooking a channel between town and Near Island, and approximately 50 feet above high water. Two large canneries, the Standard Oil dock, the U. S. Fish and Wildlife warehouse and dock, Kodiak Electric Association, and the Kodiak Airways office and maintenance hangar all fronted on the channel also, but at a lower level.

The channel alternated between calm and turbulent, the water running first one way, then the other. Many of the fishing boats had let their mooring lines go and were heading out to open water. Reports of further tidal wives began coming in. As it turned out, the second and third waves were the largest, and occurred at approximately 8:30 and 11:00 p.m., respectively.

The second wave took away the canneries, the docks, and most of the other installations along the channel, and the channel became filled with pieces of these, plus fishing boats from the adjoining boat harbor (most with their lights all on), houses, barges, etc. At times the channel would go almost completely dry, and at other times would be very high, sometimes completely calm, and then again rushing one way or the other at 20 of 25 knots. At times it looked like on enormous stretch of rapids, with great troughs and crests some 10 or 12 feet in height. The third wave took what remained of the Standard Oil dock installation, and the Kodiak Airways office (they saved only two planes), and the shoreline then had been swept clean except for KEA.

Meanwhile, according to witnesses, the small boat harbor had gotten the complete force of the water coming up and around from the channel, and with each wave became a swirling mass of boats and wreckage of the floats. The waves washed inland through most of the business district depositing buildings, boats, and other items at random throughout the area. (For those of you familiar with the area, the water reached almost up to the city hall). The telephone office and all the dialing equipment went under about eight feet, and those of us now fortunate enough to have communication with anything are using Army field phones. It will be three or four months before the phone system is again in operation.

The Griffin Memorial Hospital suffered no quake or water damage, although an after shock at 12:55 p.m., April 14 (6+ or so on the Richter scale) caused a few plaster cracks. Our solid rock underpinning here in Kodiak probably saved us from severe structural damage during the quake.

My personal feeling, as events began to unfold, was one of real loneliness. Not only was my partner, Bob Johnson, en route to Anchorage via PNA, but A. Holmes Johnson was out of town also. He was on a trip to the far east, and was almost precisely in the center of the continent of Australia, the outback, when he heard the first radio report of the quake. It was about six days later, when he was able to call Seattle from Singapore, that he first found out Bob and family were safe, and another four days before he had any idea how much of Kodiak was left.

The hospital lost electrical power when the first wave took out the cooling system running out into the channel from the power plant at KEA. With darkness descending upon us and the terrible commotion of rushing water, crashing and grinding noises, etc., just outside the hospital in the channel as all the many docks, canneries, and other facilities were being swept away, and finally because the water was becoming covered with oil and gasoline from the severed Standard Oil Company lines, it was decided to evacuate the hospital. Of some eight or nine patients present at the time, a few were allowed to leave to stay with friends or relatives in their homes. The other half dozen were taken up to the high school and bedded down in one of the rooms in charge of three of our nurses. The high school, incidentally, became the major evacuation point for all people from the low lying areas, and remained so for the following week.

Our three casualties arrived at the hospital just as the last of the patients were being transferred. They were fishermen who had been on boats in or near the boat harbor when the first wave came in. A number of boats had been broken up or capsized when they ran into fixed obstructions, or when larger vessels were thrown against them, and each of the three men mentioned above had lost crewmates or members of the family, but had been miraculously plucked from the water by other boats. All suffered from exposure. One man suffered three broken ribs, but the other injuries were all abrasions, contusions, and small lacerations, nothing major.

The ACS installation, with independent power was selected as an emergency ward and worked out quite well. Matresses, three hospital beds, medications and equipment were brought up from the hospital by volunteers and distributed to the high school and ACS. From this point onward things calmed down a bit and the situation remained under good control. Being at the nerve center of remaining communications was quite interesting there at ACS, as succeeding waves came, and as the various boats contacted reported their positions and situations. One humorous incident: when the power scow Selief contacted ACS just after the third and highest wave, and was asked for his position, he replied that he was on the side of the hill directly down from the downtown school.

The night was a long one, but probably no longer than that up in Anchorage. Bob Johnson showed up again early in the evening, tending to boost my morale greatly, but I am still thankful we weren't faced with dozens of injured. We relocated at the hospital the following morning at about 10 o'clock, our emergency line from KEA again functioning. Only minor annoyances from that point forward: x-ray inoperative for a few days because of low power, scare rumors of 90-foot waves coming for two or three days, after shocks, etc.

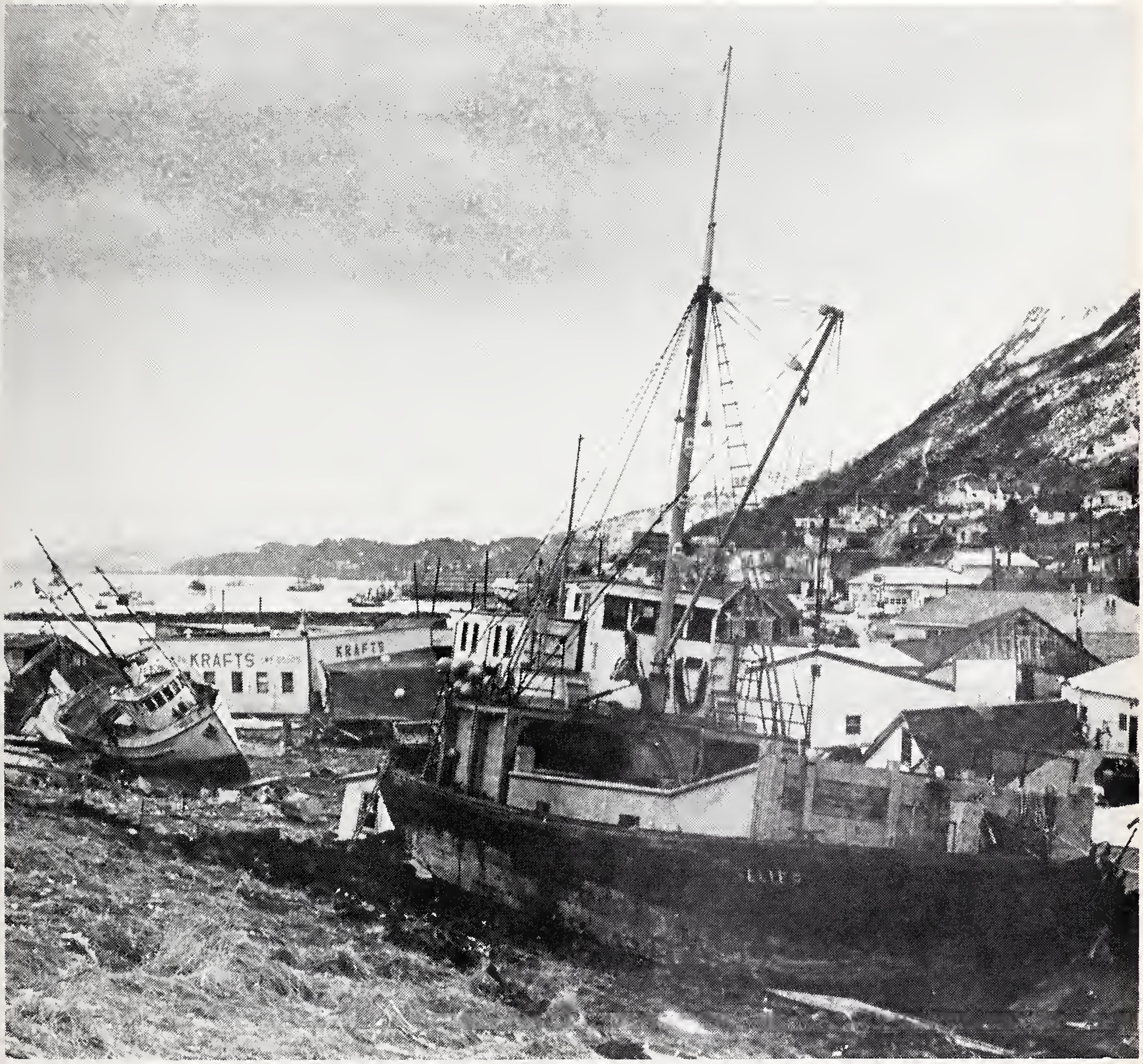
The days since the disaster have been busy ones, setting up emergency communications, salvaging, restoring partial electric power, having martial law imposed in the disaster area, and now demolition. There has been a lot of effort expended for the common good, clothing donations, Red Cross work, etc. Many people without homes have evacuated, and others are resettled with friends or in other places.

There were surprisingly few injuries, none very serious, but we did lose some eight or ten known dead and thirteen to fifteen missing, including the school music teacher and his wife who were out beachcombing at the time in Kalsin Bay.

Now we face quite a long period of readjustment and rebuilding, and much faith has been expressed by the businesses and large cannery operators that this will all be accomplished in time. One of the problems in this regard is the fact that this end of the island has apparently been lowered by six or eight feet, and all of our tides ever since the disaster have been correspondingly higher. The new construction may have to be moved inland a bit.

One wonders, after having gone through an episode like this, just how it would be possible, with power and other facilities gone, to care for hundreds, even thousands, of casualties in the event of a disaster involving more physical injuries. It's something to think about and try to plan for, but I hope we never have to face it.

According to the Encyclopaedia Britannica, people who have once experienced a severe quake are not likely to ever again view minor tremors with equanimity. Intimacy with quakes, they said, does not breed contempt. Amen from Bruce Keers, and this includes tidal waves.



Power scow *Selief*, "on the side of the hill directly down from the downtown school"

NOTES ON MEDICAL CARE RENDERED IN GLENNALLEN TO EVACUEES FROM VALDEZ

CHESTER L. SCHNEIDER, M.D.

Faith Hospital, Glennallen, Alaska

As was the case in reports received from Anchorage, most of those physically harmed as a result of the massive property destruction due to quake, water and fire in Valdez were either killed or escaped with relatively minor injury. The loss of life on the dock when it dropped into the gaping chasm was accompanied by fatal injuries on the S. S. Chena, where longshoremen were unloading deck cargo and loading surplus railroad rails into the hold. Two were killed instantly from crush injuries, another received severe fractures of the lower extremities and several received minor injuries. The third officer of the boat dropped dead suddenly the following morning, presumably from a heart attack. Dr. Clarence Davis of Valdez and Miss Betty Malay, Public Health Nurse who covers the Valdez and Copper River Valley areas (who happened to be in Valdez at the end of an immunization program) were transported to the Chena to care for the injured. The mildly injured were lightered ashore to Valdez for evacuation by highway and the seriously injured were taken elsewhere (one reportedly went to Cordova—this was not confirmed).

The military (Army) from Fort Wainwright moved down promptly, setting up evacuation headquarters with the help of Glennallen area citizens in the Glennallen High School building. One Army doctor and several medics were stationed here. Two more Army physicians went in the direction of Valdez to aid evacuees who were strewn at the few lodges between Glennallen and Valdez. One woman commenced labor symptoms at one of the lodges but discontinued sufficiently to be transported to Fairbanks. Eventually at least one doctor went to Valdez to provide medical coverage for the few families, many "town fathers" and many military personnel who commenced the staggering cleanup task. Dr. Davis remained in Valdez for several days, then went to Anchorage to evaluate the status of his "charges" from the Harborview Nursing Home of the Division of Mental Health. All these patients were transfered by plane to the Alaska Psychiatric Institute within approximately twenty-four hours after the earthquake.

Doctor Pinneo and I at Faith Hospital treated several injuries related to the earthquake violence: a fractured fibula, bruises and abrasions due to falls and two patients with mild crush injuries. One of these patients had been working in the hold of the S. S. Chena, standing only three feet from one of the fatally injured; the other man had a leg and thigh pinned in a crevice which opened under him and closed on one leg. Pre-existing respiratory or febrile illnesses were aggravated by exposure to and in water in several cases and required fairly intensive therapy. Approximately fifty patients from Valdez were treated at Faith Hospital during the first seven days after the quake, most of them as outpatients. Emotional tension ran high, particularly in those who had lost loved ones. Since both of us have been involved in providing medical care for Valdezans intermittently to a greater or less degree for over ten years, primarily at times when there was no doctor resident in the town, we could not help but feel a sincere, almost familial, sympathy for them in their time of deprivation.

Longest term care has been provided Mrs. Marguerite Harrais, 92-year-old ex-Commissioner of Valdez, who spent thirty years there and many more years in other parts of Alaska contributing significantly to the development of our State in her consistent, determined stand for good and right causes. Having been a long time asthmatic, she was a likely candidate for the bronchopneumonia which necessitated her hospitalization and resulted in her death after a month's illness.

Latest report indicated that Dr. Clarence Davis has left Alaska to enroll in post-graduate study in the Midwest. Presently Valdez has an estimated population of three hundred, of which 150 are townsfolk and the balance are military and Corps of Engineers personnel helping in the mammoth cleanup task. Two Army medical corpsmen are the only medical personnel stationed in Valdez as of this writing.

EMERGENCY OPERATIONS AT PROVIDENCE HOSPITAL

March 27, 5:30 p.m. — March 29, 5:30 p.m.

ED FORTIER*

ANCHORAGE, ALASKA

NARRATIVE ACCOUNT:

I was in my office in Providence Hospital at 5:35 p.m., finishing correspondence and preparing to leave for the day. I had been in the hospital during several previous quakes, and was not greatly alarmed by the first tremors. It soon became apparent, however, that this was a major tremor. In moving from the office to the main lobby, I slipped and fell three times. When I reached the lobby, I observed that first floor workers had moved outdoors.

Mrs. Nancy West, who was at the switchboard, was in the process of leaving the building when I met her in the lobby. We returned to the switchboard with difficulty. The internal broadcast system was operative and I told Mrs. West to broadcast: "Please remain calm. Stay in your rooms. The building will stand." She did this first while the quake was at its peak, and repeated the entire message at least once before the shaking stopped.

As soon as the worst shaking was over, Mrs. West advised me that the internal phone system, was out, but that the broadcast system was still working.

Sister Barbara Ellen had been attending Good Friday Services at St. Anthony's Church in Mountain View when the quake struck. She immediately proceeded to the church rectory and called Providence Hospital. I believe it was the last incoming call for many hours, and was received only a few minutes after the first severe shock ended. Mrs. West gave me the phone and Sister Barbara Ellen asked for a condition report. I advised her that the hospital seemed intact, but that an emergency was developing. She said she would return immediately.

I did not observe any nurse, LPN or aide from the nursing floors leave her post and descend to the main floor in seeking exit from the hospital. As soon as the severe shaking ended, first floor workers returned to the hospital. There was concern, but no sign of hysteria or incipient panic.

I was at the switchboard about 5:43 p.m., when a loud, crashing noise was heard in both elevator shafts. I assumed at the time that both elevators had dropped. (It later was learned that the elevators remained where they were, and that the noice came from falling cables.) It was unknown whether any persons might have been caught in the elevator at the time of the quake.

I walked to the Emergency Room where Mrs. Ruth Adams, R.N., nurse-in-charge, reported that the operating light was loose but workable. She also pointed to a pile of linen that had been knocked to the floor, and it was evident that some supplies were displaced and scattered. By this time the 125 KW diesel auxiliary power plant was in operation. I would estimate that not more than 3 minutes elapsed before this plant was operational.

Mrs. West confirmed that telephone links with all non-hospital points were dead, and that the internal phone system was inoperative. A kitchen worker, William Maconaghie, used the stairs to determine initially that all nursing floors were intact and personnel were functioning. Mrs. Harriet Easley, evening nursing supervisor, determined that no patients had been injured. Mr. Maconaghie was sent to the emergency room to assist Mrs. Adams in straightening the room.

It was determined that city power and water were lost to the hospital. Because it appeared possible that oxygen lines might have been broken, Mrs. West broadcast regular warnings against smoking in any area. She also repeated warnings against attempts to use the elevators.

Dr. Fred Hillman, chief of surgery on the Providence medical staff, arrived at the hospital a few minutes after the quake, and he conferred with Mrs. Easley and Mrs. Adams until the arrival of Sister Barbara Ellen.

The extent to which Anchorage and the remainder of Alaska were damaged by the quake was unknown in the earliest phase. As off-duty employees returned to work, it became apparent that there was heavy damage in the city and casualties should be expected. Shortly before 6 p.m., when it became known that approximately 22 patients would be arriving from Presbyterian Hospital, which was evacuated due to loss of water and power and leaking gas, Sister Barbara Ellen assessed the position of Providence Hospital in the emergency.

With Presbyterian Hospital inoperative and reports being received that the U.S. Air Force Hospital at Elmendorf AFB was severely damaged and had also been exacuated, it was apparent that Providence would have to serve as Anchorage's major emergency medical center.

In discussions with Dr. Don Val Langston, president of the medical staff, and Dr. Fred Hillman, chief of surgery, as well as Sister Stella Marie, assistant administrator, and her department heads and supervisors, Sister Barbara Ellen determined by approximately 6 p.m. that:

**Public Relations Director, Providence Hospital, Anchorage, Alaska; Director of Territorial Civil Defense Operations in Western Alaska from 1951 to 1957; Acting Territorial and State Civil Defense Director from 1957 to 1959.*

LIABILITIES:

1. The hospital was operational with these deficiencies:

a—For an unknown period of time, essential power would have to be provided by the 125 KW auxiliary diesel plant. Chief Engineer Philip McLean advised the auxiliary power unit could operate at least 72 hours without difficulty.

b—Internal communications were out, with the exception of the broadcast or paging system.

c—External communications were totally inoperative.

d—Water mains had been broken and additional water would be required to maintain the boilers as well as operate toilets.

e—The Radiology departments was without power for operation of major X-ray units.

f—The Laboratory and pathological area was without power for operation of equipment or lights.

g—Extensive breakage had occurred in the pharmacy area.

h—The kitchen area was without power and in serious disarray.

i—The elevators were inoperative, although by 6 p.m., the engineers had determined that no persons were trapped in them.

j—The exhaust fans within the hospital were not functioning.

2. Negative non-hospital factors which confronted Sister Barbara Ellen included:

a—Initial inability to contact other hospitals in the area, or city or state emergency centers to gain precise information concerning the situation.

b—An almost total lack of information as to the number of casualties which might be expected from Anchorage.

c—A total lack of information as to whether there were casualties in other Alaskan towns, and whether a requirement would be placed on Providence for caring for emergency cases originating from outside Anchorage.

d—Complete lack of information in the first hours as to whether such essential utility services as phones, power and water could be restored at Providence.

e—The repeated broadcast of warnings that a tidal wave was about to strike Anchorage, which would change the entire disaster picture.

f—Realization that without water, fires might at any time break out and sweep through sections of the city.

g—The continuing threat of a typhoid epidemic.

ASSETS:

3. Factors favorable to the continued emergency operation of Providence Hospital were these:

a—The engineers and Ed Crittenden, architect who assisted in design and construction of Providence, had made preliminary inspections of the entire plant by 6:15 p.m., and determined that it had suffered no major structural damage and was safe.

b—A spring which is exposed at the rear of the hospital was open and had adequate flow for pumping into hospital mains.

c—Sister Mary Eliza, pharmacist, and Miss Frances Eckley, storekeeper, had determined that despite loss from breakage and spillage, there were sufficient essential supplies on hand for emergency operations.

d—The patients had been fed just before the quake, and the problem of feeding could be deferred for at least eight hours. With a few exceptions, there was an adequate supply of food for feeding patients and workers for a minimum of three days.

e—Sister Stella Marie had reported that the surgical area, including fracture room, was operational.

f—Available, if needed, were nearly 500 gallons of pure drinking water stored in the basement as part of the Civil Defense fallout shelter program.

g—The rapid manner in which physicians and surgeons reported to the hospital for emergency work convinced the administrator that the hospital would be able to maintain full and adequate medical staffing.

h—The response of off-duty workers, who sensed their services would be needed, in reporting to the hospital for emergency duty was reassuring.

i—The element of control had been established initially by the nursing supervisor and head nurses, and all personnel had remained at their posts through the quake.

j—Although patient rooms throughout the four nursing floors were without electricity during the first post-quake hours, the nursing stations and cores were lit. Each was supplied with extension cords which could be plugged into central core outlets for providing light where needed or for operating essential electric appliances.

k—No internal oxygen or water leaks had been discovered.

l—Sewer mains in the immediate area of the hospital appeared intact.

Those supervisors who had worked with Sister Barbara Ellen during the Cuban Crisis in October, 1962, knew that she would delegate maximum operational responsibility to department heads and supervisors, so long as they performed to her satisfaction. This she did on March 27. Her demonstration of confidence in the ability of key people to make the right decisions was an important factor in development of a smooth-functioning, effective emergency team.

PREPARATIONS FOR CASUALTY CARE

Dr. Don Val Langston, assisted by Dr. Hillman, assumed charge of arranging care for casualties, assigning physicians and surgeons to tasks. I recall them determining that the emergency room and adjacent interior hallway would serve as a clearing and sorting room.

They further determined early in the emergency that so long as it was feasible, all casualties would enter through the emergency entrance, although this would not preclude use of other entrances.

In continuing the narrative, I must report that the sequence may not be in exact chronological order. There was no time for maintaining an operational log. By 6:15 p.m., the switchboard in the main lobby and the information desk in front of it had become the over-all control point for Sister Barbara Ellen. It was to this point that department heads and supervisors were summoned when such action was necessary, messages and instructions were broadcast throughout the hospital, doctors were called, and incoming inquiries and information were processed.

The City of Anchorage Fire Department Log reports that Presbyterian Hospital was evacuated shortly before 6 p.m. Sister Barbara Ellen and the nursing supervisors had determined which beds would be assigned evacuees from Presbyterian. It is estimated that the evacuated patients accompanied by nurses and aides from Presbyterian Hospital arrived at Providence shortly before 6:30 p.m. The majority, including stretcher cases, entered through the hospital's main entrance, thus leaving the emergency entrance for other casualties. Because the elevators were not operating, the ambulatory Presbyterian patients were escorted to their rooms via corridors. At this time, it was apparent that available long-handled stretchers could not be maneuvered around corners in the interior stairway. As a consequence, several casualties had to be taken from the first floor out the main entrance and then up to the designated floor by the wider exterior stairway. This situation was remedied by about 8:30 p.m. with the acquisition of short-handled stretchers. Also of interest is the fact that several casualties were moved from the emergency area to the nursing floors by being carried in moulded plastic chairs.

Shortly after 6 p.m., Miss Frances Eckley, chief storekeeper, advised that blood substitutes in a basement storage room appeared intact, but were located under a mass of fallen shelves and other supplies. A newsboy from the Anchorage Daily Times and two chums, who regularly sell papers in the hospital in early evening, volunteered to climb into the small, restricted area and retrieve a working supply of blood substitutes.

As darkness approached, Miss Eckley also determined that nurses on each floor and key personnel were equipped with flashlights and extra batteries.

Between 6:30 and 7 p.m., casualties were arriving at all four major entrances of the hospital, each of which was manned by a doctor and admitting clerk. The bulk of these casualties were delivered by private vehicle because with the entire phone system being inoperative it was impossible to call an ambulance or rescue vehicle. It was during this period that Doctors Langston and Hillman ordered mattresses removed from the vacant beds on the second floor and placed on the floor in the corridor adjacent to the emergency room. It was apparent that the casualty flow might require a holding area, and the use of mattresses would provide more space for orderly care of patients and, if necessary, movement via the stairs to the nursing floors. I believe at the peak, there were about six casualties placed on mattresses.

I would estimate that between 8 and 9 p.m., Mr. John Alcantra from Governor Egan's office and Mr. James Messick from the State Civil Defense office appeared at Providence and asked what was needed. They were advised that the hospital was in urgent need of a radio link to the city's emergency operations headquarters. Mr. Messick had no clear idea of the picture outside of Anchorage. He was told three dead were being held at Providence. In response to his question as to what should be done if fatalities exceeded the capacity of existing mortuaries, Dr. Michael Beirne, Providence pathologist, added that in view of the freezing weather, the corpses should be held outdoors. Mr. Alcantra advised he would attempt to get a radio car to the hospital, and the two men left.

WATER SUPPLY PROBLEMS

Even before the heavy flow of casualties started arriving, and while it was still daylight, it was realized that with no water coming into the hospital through city mains, maintaining a supply of water for the boilers and toilets would be a critical problem. I recall visiting the exposed spring at the rear of the hospital with an engineer and several doctors, and determining that it would be the best hope for an emergency water supply. A truck-mounted pump from City of Anchorage Water Department arrived before 7 p.m., and laid suction hose from the spring to the pump, and from the pump into the water main in the hospital boiler room—a distance of approximately 180 feet.

Because it was supplied through a one and one-half inch hose pumped at 35 pounds pressure, the supply of spring water could do little more than maintain the boilers and toilet system at the lowest possible operational level. After loss of the normal city water supply, the water remaining in the hospital pipes was slowly depleted. The process of building this supply back with pumped in spring water was slow, but through judicious use of toilets and water, the system was slowly replenished. The low water supply was a continuing concern both of the doctors and engineers, but the problem was eased as the hours passed. City of Anchorage records show that through diligent and concentrated work, Providence was soon receiving its regular supply of water under normal pressure through city mains.

From the beginning, Doctors Langston and Hillman were concerned about use of water for drinking. Early in the evening, warnings were broadcast throughout the hospital not to drink water from the faucets. Some treated water was delivered to the hospital and made available to the nursing floors. By 9 p.m., the Pepsi Cola Co. of Anchorage had delivered two 50-gallon drums of treated and potable water to the hospital, and one of these drums was placed on the fifth floor. Even after city water was restored and being chlorinated, all floors were advised to utilize the treated 50-gallon drum for drinking water.

Late Friday evening several chlorinators arrived at the hospital in answer to a radio appeal for such units. A small chlorinator was linked to the water intake line in the boiler room, and chlorination was commenced late Friday. As an additional safeguard, the heavily chlorinated city water was given additional treatment by the hospital chlorinator for at least a week following the quake. Not until late Saturday morning did I observe free use of water from hospital mains for drinking.

HAVEN FOR THE HOMELESS

Shortly after 6 p.m., the first of many dazed and homeless persons arrived in Providence. Focal point for these people was the lobby. Some stayed only a few hours and some stayed in and near the hospital for

48 hours. Men, women, and children were included. By 10 p.m., the lobby was so crowded that Sister Barbara Ellen arranged to have all folding chairs in the conference room moved to the main lobby for additional seating.

By 10 p.m. Friday evening, a supply of sandwiches, and coffee and canned soft drinks were available in the lobby and distributed to the homeless, as well as doctors and nurses, many of whom had had no dinner. Although there may have been brief periods of depletion, the task of providing coffee and sandwiches for all needing them continued until Sunday morning.

To accommodate homeless children and children of Providence workers who had been brought to the hospital with their parents, Sister Barbara Ellen designated the first floor conference room as a nursery. The wife of Dr. John Pennington assumed management of the improvised nursery.

Dr. Fred McGinnis, president of Alaska Methodist University, advised Sister Barbara Ellen early in the evening that AMU would provide shelter for the homeless. Accordingly, regular announcements were broadcast that homeless wanting a place to sleep, should sign up at the switchboard control desk. A number of persons did sign and were directed to the AMU dormitories.

Because a number of persons remained in the hospital, Sister Barbara Ellen directed that mattresses be placed in the physical therapy room in the basement to accommodate the homeless. Initially, there was a strong odor of natural gas in the room, coming into the hospital from a venting station about one and one-half miles east of the hospital. This odor lingered until the exhaust fan system was operative. Once the smell was gone, from 8 to 12 persons slept in the Physical therapy room. In addition, people slept sitting up in the main lobby, in the medical records room, and in lounges adjacent to rest rooms on the basement and first floors. All homeless were provided with blankets. An estimated 10 to 12 children and infants slept in the medical records room.

At about 9:30 p.m., I asked Sister Barbara Ellen if she wanted the entire lobby cleared. She advised that so long as the arriving homeless did not interfere with the care of the injured, she wanted full use made of the hospital's lobby area. In retrospect, I realize this was a wise decision. It served to reduce tension and anxiety, which are easily spread. Moreover, the men seated in the lobby provided an ideal labor pool. Several times during the evening, work parties were made up from the volunteer and homeless men who were in the main lobby area.

VOLUNTEER SERVICE AND EQUIPMENT

Although the hospital did not broadcast an appeal for volunteers, large numbers showed up during the course of the evening. Mrs. Rogers, Providence Hospital nursing director, decided early after the quake that her principal problem would be staffing shifts to come and not the immediate shift on duty. She assigned a nurse to record all volunteer nurses, LPN's and aides, and those not immediately needed were assigned a shift for the next day or the second day. This system worked well.

As the number of volunteers continued to mount, and it became apparent that the hospital requirement would be met, it was decided to announce via all radio stations that no additional volunteers were needed at Providence, and that if the need for help arose, it would be broadcast. A soldier driving an Army vehicle and a lady volunteer were given the task of delivering this message to radio stations KFQD and KENI. Nearly one hour was required for them to complete the mission.

By approximately 9 p.m., Providence had established radio links with the City of Anchorage emergency headquarters in the Public Safety Building and the State Civil Defense office on east Fifth Avenue. This was accomplished initially by a State Police car which had contact with the City Emergency Center, State CD office, Elmendorf AFB and State Police Headquarters. About 9:30 p.m., mobile radio units, operated by licensed amateur radio operators, arrived at Providence. An effort to locate a Gonset Trans-Ceiver within the hospital proved unworkable, so it was necessary to maintain one and two mobile radio units just outside the hospital's main entrance until Monday, March 30.

The mobile radios, manned by a total of 12 different operators, who rotated during the emergency, were the hospital's link with Anchorage and the world. The need was usually described to me, and I, in turn would give the message to the mobile radio operator. The radio operator would then pass the message to either the city or state emergency headquarters. In some instances, the city or state could meet the need, and, when neither could, the request was broadcast to the listening public. I believe the latter course produced bread, when it was determined the existing supply would not last. It also was used to bring the first chlorinator to the hospital. Early on Saturday morning, it was determined that the condensate pumps in the basement level air conditioning room were not working and flooding appeared imminent. A call was made for a master electerician, and this was broadcast. Within a short time, Mr. Cy Brewer, an experienced electrician with FAA, reported to the hospital. Mr. Brewer did a difficult and amazing job of rewiring the condensate pumps so they would work. In addition, he handled the wiring job which made it possible for a truck-mounted 100 KW diesel power unit provided by the Army to operate the entire kitchen area, which is not tied in with the existing auxiliary power system.

About 8 or 9 p.m. on March 27, a truck which I thought to be a Civil Air Patrol vehicle reported with additional mattresses and bed frames. During the same time period, a City of Anchorage truck reported with elements of a 200-bed emergency hospital which had been stored at Seward for several years, and apparently had been recently returned to Anchorage. The driver reported that Dr. Walkowski had surveyed the emergency medical items stored in a warehouse and had indicated the items enclosed might be required. Some C rations were included, but were never used. These emergency medical suppiles were initially stored in the hospital, and by March 29 had been moved to a covered walkway out-of-doors. To what extent these supplies were used is unknown to me, but I believe there was little requirement for them.

During the course of Friday evening, Army soldiers delivered a 300 gallon water trailer with treated water to the hospital, and it was stationed near the emergency entrance. Another Army unit delivered a 100 KW truck-mounted diesel power unit to the rear-loading platform. This was done in answer to a request from the chief engineer for a reserve power unit. Eventually, the Army diesel unit was hooked up to run the entire hospital kitchen.

By 8:30 p.m., Friday evening, the first of hard-working Army and Air Force medical corpsmen reported to Providence and were used in various capacities throughout the hospital. Military personnel were assisting in the hospital as late as April 6, ten full days after the earthquake.

Shortly before midnight on Friday, at a time when the number of casualties Providence might expect was still unknown, two large Air Force semi-trailers loaded with hospital beds reported to Providence. There being no immediate need for the additional beds, they were placed on standby with their drivers in the front parking lot. On Saturday morning, when it became evident there was no need developing for the additional beds, they were returned to Elmendorf.

MORE POWER PROBLEMS

The hospital's internal movement problem was eased shortly after midnight, early on March 28, when workmen of the Otis Elevator Co., managed to get one of the hospital elevators in operation.

City of Anchorage power was initially restored to Providence just before midnight on March 27. The hospital's Auxiliary power plant cut-off. Within what seemed a matter of minutes, the city power went off, and the entire hospital was in darkness except for flashlights. Efforts to start the auxiliary power plant did not succeed for many minutes. It was finally determined that the 24 volt batteries needed to start the plant were run down. Despite the total darkness, calm prevailed throughout the hospital.

The hospital's reserve of flashlight batteries had been exhausted and as some lights were growing dim, a radio call went out for additional batteries. The City of Anchorage Police Department responded within an hour with an adequate resupply.

By removing the 24-volt batteries from the military truck which housed the additional 100 KW diesel generator, the hospital's auxiliary power plant was started and operated continuously until firm city power was restored on either late Saturday or Sunday.

FOOD PREPARATION PROBLEMS

Early Friday evening it was determined that sufficient essential foods remained in the hospital to feed all patients and employees for three days. There was relatively little loss of food due to breakage or loss of power in the freezers. Four members of the kitchen crew remained on duty through the evening and night by alternating. They were Mrs. Wilma Tuttle, Mrs. Mary Taggart, Noreen Cahill and Rebecca Talley. An early requirement was the feeding of infants and children, the census of both having risen sharply following the quake, due to evacuees arriving from Presbyterian, and small children being among the homeless.

With electric power off in the main kitchen, water for mixing with canned formula was sterilized by boiling in the doctor's coffee urn. This procedure was explained in advance to the nursery department, which approved the emergency method. The doctor's coffee urn was activated by running an extension cord from the engineer's office to the kitchen.

Coffee was made by taking hot water from an operational kitchen tap, and was placed in containers at several strategic self-serving points in the hospital. An initial shortage of bread was remedied when a radio call went out for bread and Gilman's bakery responded with five cases of bread. Sandwiches were made throughout the night for workers and the homeless. Some of the meat used was taken frozen from the freezers. It was thawed by heating in the Sister's electric food cart or soaking in hot water, both unorthodox but effective methods of thawing frozen meat.

In accomplishing the task of doing first things first, the food carts containing trays and dishes from the evening meal were left on the floors until early Saturday morning when an elevator was made operational. Because the electric-operated dish washing machine was inoperational, all dishes for the Saturday morning breakfast had to be washed by hand. An unidentified minister of the Seventh Day Adventist Church has been named by the kitchen workers as providing outstanding assistance in returning the food carts from the floors and assisting in delivering the breakfast on Saturday morning.

The Saturday morning breakfast was delivered on schedule to all patients. It consisted of fruit juice, canned fruit, dry cereal, milk made from powdered milk and soft boiled eggs. The latter were prepared by utilizing a large steam pot which didn't require electricity.

Under normal conditions, all patient trays are made up from an electric-powered, moving tray line. With this inoperative, the Saturday morning breakfast trays were prepared by an improvised system in which each worker had a specific task to perform, completely different from her normal routine. Nevertheless, the trays arrived on time. The only complaint received on the Saturday morning meal was from a lady patient who preferred toast to plain bread. By mid-morning on Saturday, emergency power was hooked into the kitchen system and it was fully operational, including the time-saving dishwasher.

Mrs. Joan Turner, nurse on duty in Central Supply, remained at her station throughout the night until relieved about 7 a.m., March 28. Only a few bottles of Dextran were used the first 10 hours, according to Mrs. Turner. The requirement for 5 per cent glucose and water and 5 percent glucose and saline solution was greater than for Dextran, but supplies on hand were adequate. Loss of power made normal operation of the large Central Supply autoclave impossible. Early on Saturday morning, Dr. Hillman determined that additional sterilization of instruments would be required. Mobile radio units were used to call for portable sterilizers. The Army responded with a large self-contained, gas-burning unit which was located near Central Supply, assembled, but I do not believe was utilized. In the meantime, some representative of State Civil Defense arrived with a smaller, pressure-cooker type of sterilizer. It was new and still in the original carton, when unpacked by Dr. Hillman. I believe the sterilizer was obtained from parts of the 200-bed FCDA emergency hospital stored in Anchorage. Mrs. Turner prepared the sterilizer for use, and eventually about 4 or 5 a.m., set it up in the lab where it was heated by four bunsen burners. I believe one complete load of surgical instruments were sterilized in this portable unit and were made available to the Emergency Room. Between 6 and 8 a.m., on March 28, the large autoclaves in Central Supply were operational and utilized. On Saturday and Sunday, Providence was also sterilizing instruments for Alaska Native Hospital.

Shortly before midnight on March 27, seven doctors from Fairbanks arrived at Providence, having flown to Anchorage via Wien Airlines. They clearly indicated that some source in Anchorage had indicated that their services were needed during the emergency. A subsequent check, however, indicated that no doctor in Providence nor any member of the Providence administration had requested the services of the Fairbanks doctors.

Probably one of the most difficult tasks faced in the early stages of the emergency was moving full tanks of oxygen via the stairs to each of the four nursing floors. Industrial Air Products, soon after the earthquake, had delivered a reserve bank of tanks to the hospital's loading dock. Some were kept on standby and the remainder moved to the floors. The weight of the cylinders and their lack of gripping edges made them most difficult to carry. The full oxygen tanks were moved to the nursing floors early in the emergency, when it was not determined that the internal oxygen system was intact and completely safe.

Shortly after midnight, Dr. Langston called a brief meeting with Mrs. Edna Imrie, Night Nursing Supervisor, and myself in attendance. He was advised that there was an adequate reserve of drinking water in an Army trailer and Fallout Shelter storage, and that water introduced into the hospital mains was being chlorinated. Dr. Langston was also advised that city water had been restored and pressure lost initially had been fully regained and all toilets were functioning. He was given a food report and directed that all meals prepared for patients be kept simple. He directed that fresh milk on hand was to be rationed and made available only to patients on special diets and those in pediatrics. He advised that every effort should be made to conserve laundry and maximum use should be made of disposables. Mrs. Imrie gave a report on the census, condition of patients and space available.

I was subsequently told by Mrs. Myrtle Rogers, director of nurses, that every nursing service employee on the night shift had reported for duty by 11 p.m., March 27, with the exception of a nurse who had been injured in the quake.

Located in St. Mary's Residence, the original Providence Hospital, the hospital's laundry facility was operating on a limited basis on March 28. On Sunday, March 29, an alleged Civil Defense official ordered St. Mary's Residence evacuated. Colonel Oliver Seaman, commander of the USAF Hospital on Elmendorf, was notified and provided corpsmen and vehicles needed to evacuate 80 patients—the number given him by some Civil Defense official as requiring evacuation to Providence. The evacuation was completed early Sunday afternoon, March 29, and was conducted with dispatch and efficiency by the Air Force medics. It is interesting to note that Sister Barbara Ellen had not been consulted concerning the evacuation of St. Mary's Residence. On Monday, March 30, another state official inspected St. Mary Residence and determined that it was safe, a decision confirmed by later inspections. Lack of water and firm power, however, would have made it difficult to maintain St. Mary as a nursing facility. The laundry facility was also inoperative, and through the cooperation of Alaska Psychiatric Institute, Providence Hospital's laundry was processed in the API plant until about April 12, at which time the St. Mary Residence facility was restored.

EMERGENCY MEDICAL TREATMENT

To my best knowledge, there is no absolutely accurate figure on the number of persons who received medical treatment at Providence Hospital during the first 48 hours after the earthquake. An initial survey indicated 108 persons passed through the Emergency Room treatment area from 6 p.m. Friday to noon on Saturday, with eight casualties admitted. During the period from Saturday noon, March 28, to midnight on Sunday, March 29, the initial report indicated an additional 89 persons were recorded as being processed through the emergency room with a total of seven admitted as casualties. In addition to these totals, 22 patients from Presbyterian Hospital were evacuated into Providence, and an additional 27 from St. Mary Residence were moved into the hospital in the first 48 hours.

Further exploration of the number of persons processed through the emergency room in the first 48 hours has been made by nursing service and admitting personnel, and it now appears likely that the total of 197 injured and sick cared for in the period between 6 p.m., March 27 and midnight, March 29, is quite conservative. Early on Friday evening, the admitting supervisor stated that she and her assistants could not keep up with the task of properly documenting incoming injured. She advised that she would complete admission records by contacting patients in their hospital beds on Saturday morning. Thus, there were several hours when there was a possibility for an injured person to enter the hospital and be treated without being recorded. Both the nursing service and admitting personnel believe there were a number of victims who received some sort of treatment, but for whom there is no record. This being the case it appears quite likely that the medical staff treated in excess of 200 injured and sick in the first 48 hours after the quake.

Evidence of the self-discipline imposed on the injured is contained in a report of a doctor at Providence who reported the case of a man who broke his leg on Friday, but did not report to Providence until Saturday because he assumed more seriously injured should be given priority.

CONCLUSIONS:

In many years as a professional Civil Defense and disaster director and planner, I have worked with and prepared scores of exercise scenarios, which are nothing more than written outlines of simulated disasters. I cannot recall any simulated disaster exercise in which I participated in Alaska or in regional Federal Civil Defense exercises in California, in which there were more problems and prolonged unknown factors than those facing the Providence Hospital staff in the 24 hours following 5:36 p.m., March 27. In the average Control Center Disaster Exercise, the passage of time automatically provides answers to pressing questions. This did not happen to any appreciable extent in the first six hours following the quake. The total disruption of communications made accurate situation assessments impossible. In view of this, the total performance of Providence Hospital, its professional and non-professional staff during the first critical 24 hours is nothing less than amazing.

Short of war, it is seldom that medical, nursing and non-professional staffs involved in a disaster are themselves victims to the degree that existed at Providence. It was a case of victims caring for victims. One doctor appeared for emergency duty, who had lost two sons, as well as valuable property. Many other doctors had suffered heavy financial losses, and yet they continued to carry on their emergency duties. I also observed several nurses on duty, who had suffered severe financial losses.

No less impressive to me as a non-medical employee, was the demonstrated ability of doctors, nurses and other hospital workers to continue working despite being subjected to constant radio reports that a tidal wave was imminent, that fires would rage uncontrolled if they started due to lack of water, and the realization that typhoid was a threat. It seemed unlikely that a tidal wave would damage Providence Hospital, but I can only guess at the terrifying pressure which must have weighed on doctors, nurses and other workers who were on duty at the hospital, and knew that members of their families and property were in low areas which might be hit by a tidal wave. And yet, I know of no persons who left the hospital to protect his or her family in the face of the tidal wave threat.

In view of the anxiety, fears and pressures generated by the unknown factors listed above, it would not have been unexpected if there had been some breakdown in control or discipline during the first critical hours. To my best knowledge and as a result of close observation, I never noticed the slightest deterioration in operations, order, control or discipline. At no time did I hear or observe any shouting, arguing or disagreement. The professional competence and dedication of doctors accounts for this. Another contributing factor, I believe, was the presence of competent, professional nursing supervisors who knew their workers, their jobs and their hospital. Among there were Mrs. Mildred Rogers, Mrs. Harriett Easly, Mrs. Edna Imrie, Mrs. Ruth Adams, Mrs. Pat Kruse, Mrs. Mildred Cruze, Mrs. Ann Whitley, Mrs. Vanda Sweet, and Miss Marie Lilleston, who remained in Providence for three days. These nursing supervisors were known to the doctors, had the full confidence of Sister Barbara Ellen, and provided examples of quiet competence that contributed much to a successful team effort. Certainly, the example of Sister Barbara Ellen, who administered with patience and understanding, was a major factor in keeping the hospital team intact. It is difficult to imagine a hospital administrator facing more important unknown factors than those confronting Sister Barbara Ellen on March 27. She remained fully clothed for 40 hours, pausing only for brief rests.

For the first six hours following the quake, Providence operated almost entirely as a self-contained emergency facility. Although some help was received from outside, principal reliance was on the professional skills, manpower, supplies and equipment contained within the hospital.

I am not in any way qualified to evaluate the emergency work done by Anchorage doctors during the first 48 hours of the earthquake emergency. I was impressed by their response and their control and calm reactions. The leadership and command appeared to me to be most effective.

Long after the medical emergency had ended, Dr. Fred Hillman advised me that he knew of no patient admitted to Providence in the first 72 hours following the disaster who did not receive adequate care and the treatment indicated.

In evaluating Providence Hospital's over-all performance, it should be noted that a revised emergency fire plan has been in preparation for Providence for some time. On March 18, Sister Barbara Ellen called a meeting of all department heads and supervisors, and presented each with a draft of the plan. There was general discussion of it, and the actions to be taken in event of fire. The plan had previously been reviewed by Fire Chief George Burns and given general approval as workable and feasible. Sister Barbara Ellen directed each supervisor to carefully review the plan and be prepared to discuss it further at a meeting on March 25.

Captain Jack Houghton, fire prevention officer for the City of Anchorage Fire Department, participated in the March 25 meeting of department heads and supervisors. The entire plan was reviewed during the hour-long meeting, and Captain Houghton answered several questions, in addition to agreeing to conduct fire defense training sessions and fire drills. Sister Barbara Ellen gave final approval to the plan and directed that it be mimeographed in quantity and every hospital employee be given a copy.

It is also significant to note that on March 25 and 26, a 28-minute film, "They Called It Fireproof" was shown in the physical therapy gym room to hospital workers on both the day and evening shifts. The graphic film demonstrated right and wrong actions in time of emergency, and emphasized the need for maintaining calm and preventing panic. It seems quite likely that the fire plan meetings with department heads and supervisors and the subsequent showing of the fire film to most hospital employees in the two days preceding the earthquake were positive factors and contributed to the fine way in which hospital workers met the emergency.

Finally, the ability and resourcefulness of all concerned to adapt and improvise in meeting and solving emergency problems was most impressive. No plan could possibly have anticipated the wide range and variety of problems which developed, and yet all were finally solved.

RECOMMENDATIONS:

1. There is an urgent need for installing an emergency radio transmitter-receiver within Providence Hospital. (Through the efforts of the City of Anchorage, and Merrill Mael, director of emergency information for the Greater Anchorage CD District, the installation of an emergency radio has been made in the hospital.)

2. The existing 125 KW diesel auxiliary power unit is not adequate for full-scale emergency operations at Providence. Providence Hospital's normal consumption is slightly more than 500 KW during full operations. It would appear that a minimum of an additional 150 or 200 KW auxiliary power unit is needed to meet minimum emergency requirements, including hook-up of the laboratory, X-ray area, pharmacy, kitchen, condensate pumps and air exhaust system.

3. The spring which flows at the rear of Providence Hospital provides a steady flow of potable water, believed sufficient to meet the drinking, boiler and sanitary needs of the hospital. It is recommended that the city or state give consideration to establishing an emergency pump station at the point where the spring emerges from the hospital.

4. It is recommended that chlorinator be installed on standby status in the hospital boiler room, ready for immediate activation if needed.

5. It is recommended that a supply of short-handled stretchers, preferably of aluminum construction, be stored within the hospital.

6. It was observed that certain blood substitutes and transfusion kits were delivered to the hospital following the emergency were addressed to the undersigned. In view of the fact that I have been out of the Civil Defense field for six years, and these expendable and badly out-dated supplies were delivered to Anchorage several years before my departure, it is recommended that City of Anchorage health officials act to survey such emergency supplies and destroy those which are out-dated and of no value.

7. It is recommended that the Greater Anchorage Civil Defense District issue identifying vehicle and personal passes for doctors, nurses and other essential hospital personnel in Anchorage.

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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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ATHEROSCLEROTIC CORONARY HEART DISEASE

The Major Challenge to Contemporary Public Health and Preventive Medicine*—Part I

JEREMIAH STAMLER, M.D.

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This paper attempts to evaluate four major questions confronting contemporary American medicine: (1) The evolution of the public health situation in the United States in the twentieth century; (2) the scope and nature of the chronic disease problem in this country today; (3) the research advances indicating the possibility of a successful preventive advance against the major chronic disease, atherosclerotic coronory heart disease; and (4) the current status of the research and developmental efforts to achieve effective primary and secondary prevention of this disease, and the responsibilities of medicine and public health in these efforts.

The evolution of the U.S. public health situation: As is well known, the public health situation has changed drastically in this country in the last sixty years, with the noninfectious chronic diseases replacing the acute infectious diseases as the cardinal and most pressing health problems. It is valuable, by way of introduction, briefly to review and summarize what has happened. First and foremost is the very significant fact that in the twentieth century, approximately 25 years have been added to the life span of newborn American infants (Table 1). It has gone up from about 45 years in 1900 as an average figure, to almost 70 years today. These are approximate overall averages. It is worthwhile to examine the detailed data with respect to the major sex-race groups, because this helps to pinpoint the chronic disease problems. Thus, the best life expectancy today is that of a new-born white female baby—73.9 years. The white male baby has a life expectancy of 67.3, a sex differential of almost six years—to be discussed later, since it merits detailed attention. Negro new-born infants, male or female, are about six or seven years worse off in their life expectancy today, compared to corresponding white babies of like sex.

The sex differential in life expectancy has increased significantly in the twentieth century, mounting continuously to attain today's big differential of six years — for both whites and

TABLE 1

Life Expectancy at Specified Ages for the U. S. Population by Sex and Color, 1900-59

Years	White Male			White Female			Nonwhite Male			Nonwhite Female		
	At Birth	Age 40	Age 60	At Birth	Age 40	Age 60	At Birth	Age 40	Age 60	At Birth	Age 40	Age 60
1900-02	48.2	27.7	14.4	51.1	29.2	15.2	32.5	23.1	12.6	35.0	24.4	13.6
1909-11	50.2	27.4	14.0	53.6	29.3	14.9	34.0	21.6	11.7	37.7	23.3	12.8
1919-21	56.3	29.9	15.2	58.5	30.9	15.9	47.1	26.5	14.7	46.9	25.6	14.7
1929-31	59.1	29.2	14.7	62.7	31.5	16.0	47.6	23.4	13.2	49.5	24.3	14.2
1939-41	62.8	30.0	15.0	67.3	33.2	17.0	52.3	25.2	14.4	55.5	27.3	16.1
1949-51	66.3	31.2	15.8	72.0	35.6	18.6	58.9	27.3	14.9	62.7	29.8	17.0
1959	67.3	31.5	15.8	73.9	36.9	19.4	60.9	27.3	14.9	66.2	32.1	17.8
Increase (%) 1900-02 to 1959	39.6	13.7	9.7	44.6	26.4	27.6	85.5	20.3	15.1	86.3	28.3	27.9
Increase (%) 1919-21 to 1959	19.5	5.4	3.9	26.3	19.4	22.0	28.0	4.9	1.4	39.0	22.3	18.4
Increase (%) 1939-41 to 1949-51	5.6	4.0	5.3	7.0	7.2	9.4	12.6	8.3	3.5	13.0	9.2	5.6
Increase (%) 1949-51 to 1959	1.5	1.0	0.0	2.6	3.7	4.3	3.4	3.7	0.0	5.6	7.7	4.7

---

*Presented at the 19th Annual Convention of the Alaska State Medical Association, Ketchikan, May 28, 1964.

TABLE 2

Per Cent of Individuals Dying in Infancy and Childhood, by Sex and Color, United States, 1901 and 1959

	All Races, Both Sexes			White Male			White Female			Non-white Male			Non-white Female		
	<1*	1-4*	5-14*	<1	1-4	5-14	<1	1-4	5-14	<1	1-4	5-14	<1	1-4	5-14
1901	14.1	6.8	3.5	15.3	7.0	3.6	12.3	6.4	3.3	33.3	14.4	7.2	28.7	13.5	7.5
1959	2.9	0.4	0.5	2.9	0.4	0.5	2.2	0.3	0.3	5.6	0.8	0.7	4.5	0.7	0.5
Decline (%) 1901-59	79.4	94.1	85.7	81.0	94.3	86.1	82.1	95.3	90.9	83.2	94.4	90.3	84.7	94.8	93.3

*Age period.

Negroes. The race differential has narrowed. In 1900, the race differential in life expectancy of new-born infants was over fifteen years. It has now been narrowed to about six, almost certainly due to improved social conditions for Negroes, including better preventive medicine and medical care. It is sound to infer that this differential has to do with social conditions and has little to do with inherent, genetic racial characteristics.

This great increase in life expectancy in the twentieth century is overwhelmingly due to achievements with respect to infectious diseases—chiefly the infectious diseases of infancy and childhood. A few additional statistics serve to drive this point home. In 1900, of a thousand new-born white infants, about 200 or 250 were destined to die before their fifteenth birthday—200 or 250 (Table 2)! The corresponding figures for Negroes were about 500 or 550 dead by their fifteenth birthday—500-550 per thousand! This, of course, was due to the tremendous toll exacted by the infectious diseases, particularly during the first year of life.

Contemporary conditions in this area are a far cry from the situation prevailing early in the 1900s. When one wished at the turn of the century to rear three or four children to adulthood, one had several babies because it was "par for the course"—part of the natural sequence of events—for two or three to die in infancy or childhood, usually from infectious diseases. Today, of a thousand new-born white infants only 30 or 40 are destined to die before their 15th birthday; for Negroes, the figure is about 60 or 70—a tremendous decline in a few decades. Mortality in the first 15 years of life, in the first five years, in the first year has been cut tremendously. The reduction is in the order of 80% to 95%. It is this phenomenal decrease in mortality in infancy and childhood—due to the conquest of infectious diseases, to improvement in the standard of living, improved nutrition, improved sanitation, improved medical care and mass immunization—that largely accounts for the overall increase in the life expectancy.

If the aim is to see the whole picture, then it must be further stressed that this achievement has been confined to the economically developed countries. By and large it is far from achieved for a majority of mankind, living in the econom-

TABLE 3

Life Expectancy in the Economically Developing Countries

Country	Year	Expectation of Life at Birth		
Africa				
Central African Republic	1959		35	
Congo (Leopoldville)	1950-52	38*		40†
Ghana	1949		38	
Guinea	1954-55		31	
Ivory Coast	1956-58		35	
Mauritius	1951-53	50		52
North Rhodesia (Indigenous popl)	1950		37	
South Rhodesia (Indigenous popl)	1953-55	48		49
Senegal	1957		37	
Zanzibar	1958		43	
Pemba	1958		40	
South America				
Argentina	1947	57		61
Brazil	1940-50	39		46
British Guinea	1945-47	49		52
Chile	1952	50		54
Asia				
Cambodia	1958-59	44		43
China (Taiwan)	1959-60	61		66
Fed. of Malaya	1956-58	56		58
India	1941-50	32		32
Thailand	1947-48	49		52

*Male
†Female

ically underdeveloped nations of Asia, Africa and Latin America (Table 3). (These statistics lie behind our daily headlines reporting political unrest and social ferment in these lands).

Now, to the nub of present-day problems: When one poses the additional question, what is the life expectancy today of a person age 40, compared with a person age 40 in 1900, then one finds that the improvement in life expectancy for persons of this age has been discouragingly slim—particularly for the males, most particularly for the white males (Table 1). For the ladies, almost eight years have been added to life expectancy at age 40 compared to 1900. For the men, only four years have been added. Progress has really been slight in this area. Adult males cannot expect to live much longer today than their counterparts could in 1900.

The reasons for this are readily apparent—and directly related to the central theme of this paper. That is, while tremendous progress has been made in this century against the infectious diseases and against the forms of malnutrition represented by under-nutrition (e.g. scurvy, pellagra, beriberi, rickets), significant progress has not yet been made against the major chronic diseases which shorten the life span and produce large scale and premature chronic disability, making life burdensome in middle-age for all too many. The major challenge today is to move forward on this front. In the twentieth century, medicine and public health have stormed the fortresses and breached the ramparts of two great killers—acute infection and under-nutrition—the two scourges of plague and starvation stalking and devastating mankind for countless centuries. However, a forbidding barricade still lies astride the way to the high road of health and longevity in maturity. Hence for public health and medicine there are indeed "worlds to conquer". For no major additional advances in life expectancy are possible in the United States in the decades ahead unless significant progress is made first and foremost against the chronic diseases that today produce so much morbidity and mortality—not only among the elderly, but among the middle-aged population as well.

In contrast to the advances made against infectious diseases and malnutrition, the chronic diseases, which also existed in 1900, persist today largely unabated. Moreover, they have emerged as much more important problems both relatively and absolutely. They have emerged relatively, because the problems of infectious disease and under-nutrition have been more or less mastered and have therefore diminished markedly in their impact.

Dr. Paul Dudley White, in a talk before the American Society for the Study of Arteriosclerosis a few years ago, vividly described the situation prevailing when he was a young physician early in this century. At that time the problem was, can hospital beds be made available fast enough to take care of the cases of typhoid fever. This is indeed a far cry from the present situation.

Incidentally, the fact that that was the problem is a wonderful illustration of a truth that needs to be driven home continually to citizens and statesmen, to the body politic in general, to responsible people in health and medicine. It is a truth pregnant with meaning in relation to the chronic diseases and our big problems today—namely that it is almost always much cheaper to bring about preventive medicine for the tens of millions than it is to provide therapeutic medicine for serious frank illness among tens of thousands. This thesis is presented in this crass way—in hard cash terms, so to speak—because an appeal to humanitarianism, to the welfare of people is unfortunately not enough. Proposals for the distribution of the national income and the share of it assigned overall to health services must be justified and defended dollar-wise. It is a very important aspect of that justification, that—as with the infectious diseases, so with the chronic diseases—effective primary and secondary prevention are not only useful in that they bring well-being to people. Costs—even when the measures reach out to serve large populations—are often less than would have otherwise been incurred for the care of severe illness. In other words, the end result of the "big" preventive programs often is an overall saving of money. This is a very important point.

Be that as it may, a relative change in the situation has certainly occurred, namely the chronic diseases have come to the fore because other diseases have been pushed into the background. Here it is necessary to stress, in all conscience, that what has been pushed into the background will remain in the background only as long as vigilance is maintained with respect to the infectious diseases, nutrition, etc. And as the world shrinks in size and the population increases, the problem of vigilance against the infectious diseases becomes more complex, not less complex. The so-called old public health approaches are here to stay!

The scope and nature of the U.S. chronic disease problem today: It is not only relatively, however, that the chronic diseases have come to the fore. They have come to the fore in two other respects. First of all, since many people have been kept alive who would previously have died in childhood, the adult population at risk with respect to the chronic diseases has been increased markedly. While the population of the United States as a whole has increased about 140% in the twentieth century, the population 45 to 64 has increased 250 % (Table 4). And, the population 65 and over has undergone an even greater increase. Therefore a disproportionate increase has occurred in the number of people reaching the decades of life in which the chronic diseases are common. The result has been a gross increase in the absolute number of people with chronic diseases. This, it should be emphasized, is irrespective of any increase in age specific rates. It merely results from the fact that there are more people at risk.

TABLE 4

U.S. Population, 1900-1970, by Age

Year	All Ages	45-64 Years	65 and + Years
1900†	76,094,000	10,466,000	3,100,000
1950†	151,683,000	30,837,000	12,287,000
1960‡	180,677,000	36,208,000	16,658,000
1970‡	Series II*: 214,222,000 Series III*: 208,931,000	42,265,000	20,035,000
1900-1960 Pct Increase	137.4%	246.0%	437.4%

†Series A 22-33, Estimated Population, by Sex, Color, and Age. 1900-1957. p. 8, **Historical Statistics of the United States.**

‡Table No. 3, Total Population, by Age and Sex: 1960 and Projections to 1970. p. 6, **Statistical Abstract of the United States, 1962.**

*Two different assumptions on fertility in period 1965-1970.

But even this is not the whole story. There is good reason to believe (despite all the limitations in time trend statistics) that an absolute increase has occurred in the age specific rates of certain

TABLE 5A

Age Adjusted Death Rates, All Causes, Cardiovascular-Renal and Non-Cardiovascular-Renal Diseases, U.S. Population by Sex and Color, 1920-1959*

		Death Rates per 100,000 Population				
Cause	Year	Both Sexes, All Races	White Male	White Female	Non-White Male	Non-White Female
All Causes	1920	1424	1421	1314	2042	2098
	1930	1246	1276	1058	2100	1921
	1940	1076	1155	879	1764	1505
	1950	842	963	645	1358	1096
	1959	770	925	566	1258	925
Cardiovascular-Renal Diseases	1920	471	476	449	567	618
	1930	491	509	429	752	729
	1940	486	535	403	691	647
	1950	440	514	339	634	571
	1959	408	500	301	603	495
Non-Cardiovascular-Renal Diseases	1920	953	945	865	1475	1480
	1930	755	767	629	1348	1192
	1940	590	620	476	1073	858
	1950	402	449	309	724	525
	1959	362	425	265	655	430
Percent Change, All Causes	1920-1959	−46.0%	−34.9%	−56.9%	−38.4%	−55.9%
	1940-1950	−21.7%	−16.6%	−26.6%	−23.0%	−27.2%
	1950-1959	− 8.6%	− 3.9%	−12.2%	− 7.4%	−15.6%
Percent Change, CVR Diseases	1920-1959	−13.4%	+ 5.4%	−33.0%	+ 6.3%	−19.9%
	1940-1950	− 9.5%	− 3.9%	−15.9%	− 8.2%	−11.7%
	1950-1959	− 7.3%	− 2.7%	−11.2%	− 4.9%	−13.3%
Percent Change, Non-CVR Diseases	1920-1959	−62.0%	−55.0%	−69.4%	−55.6%	−70.9%
	1940-1950	−31.9%	−27.6%	−35.1%	−32.5%	−38.8%
	1950-1959	−10.0%	− 5.3%	−14.2%	− 9.5%	−18.1%

*The age-adjusted rates were computed by the direct method, using the total population as enumerated in 1940 as the standard.

TABLE 5B

Death Rates, All Causes, Cardiovascular-Renal and Non-Cardiovascular-Renal Diseases, U.S. Population Age 45-54 by Sex and Color, 1920-1959

Cause	Year	Death Rates per 100,000 Population				
		Both Sexes, All Races	White Male	White Female	Non-White Male	Non-White Female
All Causes	1920	1219	1198	1087	2009	2335
	1930	1218	1231	925	2633	2518
	1940	1060	1139	747	2453	2109
	1950	854	984	546	1857	1555
	1959	733	909	445	1511	1098
Cardiovascular-Renal Diseases	1920	387	350	359	707	923
	1930	444	417	325	1152	1201
	1940	439	480	278	1072	1058
	1950	412	508	217	903	862
	1959	341	472	150	735	573
Non-Cardiovascular-Renal Diseases	1920	832	848	728	1302	1412
	1930	774	814	600	1481	1317
	1940	621	659	469	1381	1051
	1950	442	476	329	954	693
	1959	392	437	295	776	525
Percent Change, All Causes	1920-1959	−39.9%	−24.1%	−59.1%	−24.8%	−53.0%
	1940-1950	−19.4%	−13.6%	−26.9%	−24.3%	−26.3%
	1950-1959	− 8.5%	− 7.6%	−18.5%	−18.6%	−29.4%
Percent Change, CVR Diseases	1920-1959	−11.9%	+34.9%	−58.2%	+ 4.0%	−37.9%
	1940-1950	− 6.2%	+ 5.8%	−21.9%	−15.8%	−18.5%
	1950-1959	−17.2%	− 7.1%	−30.9%	−18.6%	−33.5%
Percent Change, Non-CVR Diseases	1920-1959	−52.9%	−48.5%	−59.5%	−40.4%	−62.8%
	1940-1950	−28.8%	−27.8%	−29.8%	−30.9%	−34.1%
	1950-1959	−11.3%	− 8.2%	−10.3%	−18.7%	−24.2%

TABLE 5C

Death Rates, All Causes, Cardiovascular-Renal and Non-Cardiovascular-Renal Diseases, U.S. Population Age 55-64 by Sex and Color, 1920-1959

Cause	Year	Death Rates per 100,000 Population				
		Both Sexes, All Races	White Male	White Female	Non-White Male	Non-White Female
All Causes	1920	2359	2421	2171	3114	3580
	1930	2403	2552	1993	4039	4143
	1940	2216	2522	1684	3711	3318
	1950	1901	2304	1294	3481	2763
	1959	1712	2203	1064	3211	2405
Cardiovascular-Renal Diseases	1920	1040	1056	956	1449	1730
	1930	1140	1200	913	2170	2311
	1940	1122	1305	793	1992	1955
	1950	1068	1337	664	1995	1760
	1959	939	1262	518	1795	1467
Non-Cardiovascular-Renal Diseases	1920	1319	1365	1215	1665	1850
	1930	1263	1352	1080	1869	1832
	1940	1094	1217	891	1719	1363
	1950	833	967	630	1486	1003
	1959	773	941	546	1416	938
Percent Change, All Causes	1920-1959	−27.4%	− 9.0%	−51.0%	+ 3.1%	−32.8%
	1940-1950	−14.2%	− 8.6%	−23.2%	− 6.2%	−16.7%
	1950-1959	− 9.9%	− 4.4%	−17.8%	− 7.8%	−13.0%
Percent Change, CVR Diseases	1920-1959	− 9.7%	+19.5%	−45.8%	+23.9%	−15.2%
	1940-1950	− 4.8%	+ 2.5%	−16.3%	+ 0.2%	−10.0%
	1950-1959	−12.1%	− 5.6%	−22.0%	−10.0%	−16.6%
Percent Change, Non-CVR Diseases	1920-1959	−41.4%	−19.7%	−55.1%	−15.0%	−49.3%
	1940-1950	−23.9%	−20.5%	−29.3%	−13.6%	−26.4%
	1950-1959	− 7.2%	+13.3%	−13.3%	−4.7%	−6.5%

TABLE 6

Mortality Rates per 100,000 Population, 1950 and 1960
All Causes and Major Cardiovascular-Renal Causes by Age-Sex-Color

Age-Sex-Color Group	All Causes		Cardiovascular-Renal Diseases		Arteriosclerotic Heart Disease		Arteriosclerotic and Degenerative Heart Disease		Hypertensive Disease		Cerebro-vascular Diseases	
	1950	1960	1950	1960	1950	1960	1950	1960	1950	1960	1950	1960
White Males												
45-49	660.4	709.3	374.6	347.9	236.4	254.9	255.3	262.1	27.2	13.4	37.9	28.7
50-54	1,089.0	1,183.3	653.0	625.6	417.2	462.6	449.6	478.9	55.0	25.7	70.9	54.7
55-59	1,734.7	1,784.6	1,065.5	989.8	667.3	719.0	730.2	746.2	93.9	46.4	131.8	97.1
60-64	2,642.4	2,751.4	1,659.1	1.590.5	985.3	1,119.1	1,101.7	1,172.6	149.0	78.4	242.0	189.1
White Females												
45-49	411.5	368.5	161.3	109.0	43.5	40.8	53.5	43.9	24.9	9.9	41.1	25.3
50-54	622.5	560.3	277.9	198.0	91.7	85.6	108.8	92.0	47.8	18.7	70.1	43.3
55-59	978.0	829.7	488.6	357.0	185.7	183.6	219.7	195.6	75.6	34.4	116.4	69.0
60-64	1,568.6	1,362.2	878.9	706.2	364.3	384.4	432.5	411.9	137.2	67.8	204.8	141.6
Non-White Males												
45-49	1,264.9	1,241.5	640.1	546.1	182.7	224.8	238.2	244.1	150.2	106.1	141.2	119.9
50-54	2,139.7	1,916.2	1,217.1	923.3	339.8	382.1	463.1	419.3	287.5	170.2	279.7	200.1
55-59	2,936.0	2,500.5	1,729.4	1,338.3	491.4	556.1	659.1	626.1	384.3	233.0	419.4	313.3
60-64	3,738.8	4,053.8	2,384.5	2,293.0	634.4	956.0	911.8	1,090.5	503.1	376.1	556.0	547.2
Non-White Females												
45-49	1,208.1	919.4	666.1	436.1	124.2	124.7	176.3	138.0	189.0	106.3	189.7	121.2
50-54	1,890.0	1,419.5	1,107.8	738.3	217.4	220.7	304.8	253.2	308.0	176.4	312.4	207.9
55-59	2,350.2	1,951.8	1,478.2	1,138.7	302.5	366.2	446.3	361.0	402.8	249.9	416.5	330.4
60-64	3,180.3	3,019.5	2,126.3	1,889.0	450.3	636.9	676.3	559.1	549.4	392.0	618.3	561.0

diseases. Thus, for the key cardiovascular-renal grouping as a whole—a broad grouping of many diseases, but principally atherosclerotic and hypertensive diseases—the data indicate that from 1920 to about 1940 mortality rates for middle-aged white males rose significantly (Table 5). In the late 1940s and early 1950s these rates plateaued and then began to go down slightly.

There is considerable reason to believe that in the twentieth century the middle-age-specific mortality rates for atherosclerotic coronary heart disease in white males rose substantially—and either they are continuing to rise slightly or have plateaued recently (Table 6). There is no evidence yet of a downturn in the coronary heart disease mortality rate among males nationally.

In noting this increase in certain diseases, one cannot fail to emphasize the catastrophic increase in the occurence of certain cancers, particularly carcinoma of the lung. For many of the age-sex-race specific groups, the mortality rates in middle age due to this carcinoma have almost doubled from 1950 to 1960. Certainly this is not an artefact resulting from better diagnosis, but a true increase—attributable mostly to the impact of twentieth century cigarette smoking habits.

There is also reason to believe that an increase has occurred in incidence and mortality rates (including premature mortality rates) from chronic broncho-pulmonary diseases, i.e. asthma, emphysema, bronchiectasis, chronic bronchitis. These diseases—related to air pollution and smoking, particularly cigarette smoking with inhaling—are also on the increase in an absolute sense. They are already prime problems in Great Britain. While the American situation is not yet nearly as serious as Britain's, it is indeed serious enough to warrant a warning note and a call for preventive approaches, before another chronic illness problem mounts to major proportions.

Up until the last few sections, the chronic diseases have been discussed in general, as a broad group, without indicating specifics or defining terms. It is essential to get down to delineating and defining specific disease entities if the objective is development and application of preventive approaches. The assignment of specific diseases to the chronic disease group is, of course, within limits an arbitrary matter. Thus, a disease like tuberculosis can manifest marked chronicity, as is well known, but through custom it is not included among the chronic diseases. The major chronic diseases are:

(a) Certain diseases of the cardiovascular system, first and foremost among these, hypertensive disease and atherosclerotic disease, also (far less significant nowadays) rheumatic heart disease;

(b) diabetes mellitus, of key importance today because of the added risk it gives of sickness, disability and death from cardiovascular diseases, hypertensive, atherosclerotic, arteriolosclerotic;

(c) chronic urinary tract infection, apparently a major problem, especially in women;

(d) chronic bronchopulmonary disease, involving primarily the lungs, but eventually also the heart, in chronic cor pulmonale or pulmonary heart disease;

(e) the neoplastic diseases;

(f) arthritis and rheumatism, another major grouping, for which public health has little or no preventive approach to date;

(g) the mental illnesses, classified by some, but not others, with the chronic diseases;

(h) finally, very properly included with the chronic diseases, to which it contributes most significantly and deplorably, a major form of nutritional disease today—obesity, chronic malnutrition in the form of overnutrition.

Among these chronic diseases, the cardiovascular entities—particularly hypertensive and atherosclerotic diseases—are far and away the chief producers of morbidity, disability and mortality both in the middle-aged and elderly strata of the U.S. population today. One disease—atherosclerotic coronary heart disease—alone accounts for one third or more of all deaths in white males age 45-64, and exacts a high toll in all the other sex-race groups as well (Table 6).

The validity of this conclusion was once again verified by the data collected in an important survey recently completed by the Chicago Association of Commerce and Industry in cooperation with the Chicago Heart Association. This study demonstrated that in 1961 diseases of the heart and blood vessels were responsible for an absolute majority of deaths among 312,229 employees of 18 major Chicago companies. Cardiovascular diseases killed 616 persons, their toll being particularly heavy—441 deaths—among men age 45-64. They struck indiscriminately among managerial and supervisory personnel, technical and clerical employees, skilled, semi-skilled and unskilled.

These findings are quite typical for the United States today. They have been repeatedly recorded in longterm prospective epidemiologic studies, such as the one being conducted by our group in the labor force of the People's Gas, Light and Coke Company and that of colleagues in the Western Electric Company in Chicago, in Framingham, New York City, Tecumseh, Albany, Wilmington, Charleston, San Francisco, Los Angeles, etc.

A more detailed review of the cardinal findings of these investigations serves to highlight the key challenges confronting medicine and public health today. The research in the People's Gas Company began in 1957. Extensive data on the male labor force age 40-59 were collected and analyzed in 1958. The findings, it is appropriate to reiterate, well represent the situation in this country today. Almost one-third of the middle-aged men were found to have one or more detectable abnormalities of the cardiovascular system (Fig. 1). In many cases it was "only" elevated blood pressure, without any demonstrable abnormalities in the blood vessels. In 182 per thousand men (almost 20%), there was demonstrable disease in blood vessels. In 46 per thousand, hypertensive heart disease was present; in another 46 per thousand, atherosclerotic coronary heart disease. These two separate but interrelated processes—hypertension and atherosclerosis—are the major cardiovascular problems today. Note also the sizeable group of individuals who, because of their symptoms or their electrocardiographic findings, were evaluated as having suspect coronary disease (Fig. 1). A definitive diagnosis could not be made, but there was enough evidence of disease so that they could not be given a clean bill of health.

The data in Figure 1 present a "still picture" of the disease situation in a population at a given point in time. For both practical and research reasons, it is at least as important to get a "moving picture", that is, an analysis of the rate of development of new disease over time in persons originally healthy. Of the 1465 middle-aged men in the Chicago Utility Company Study, 1329—with no history of heart attack at the time of initial examination in 1958—have been followed in detail without systematic intervention by the research

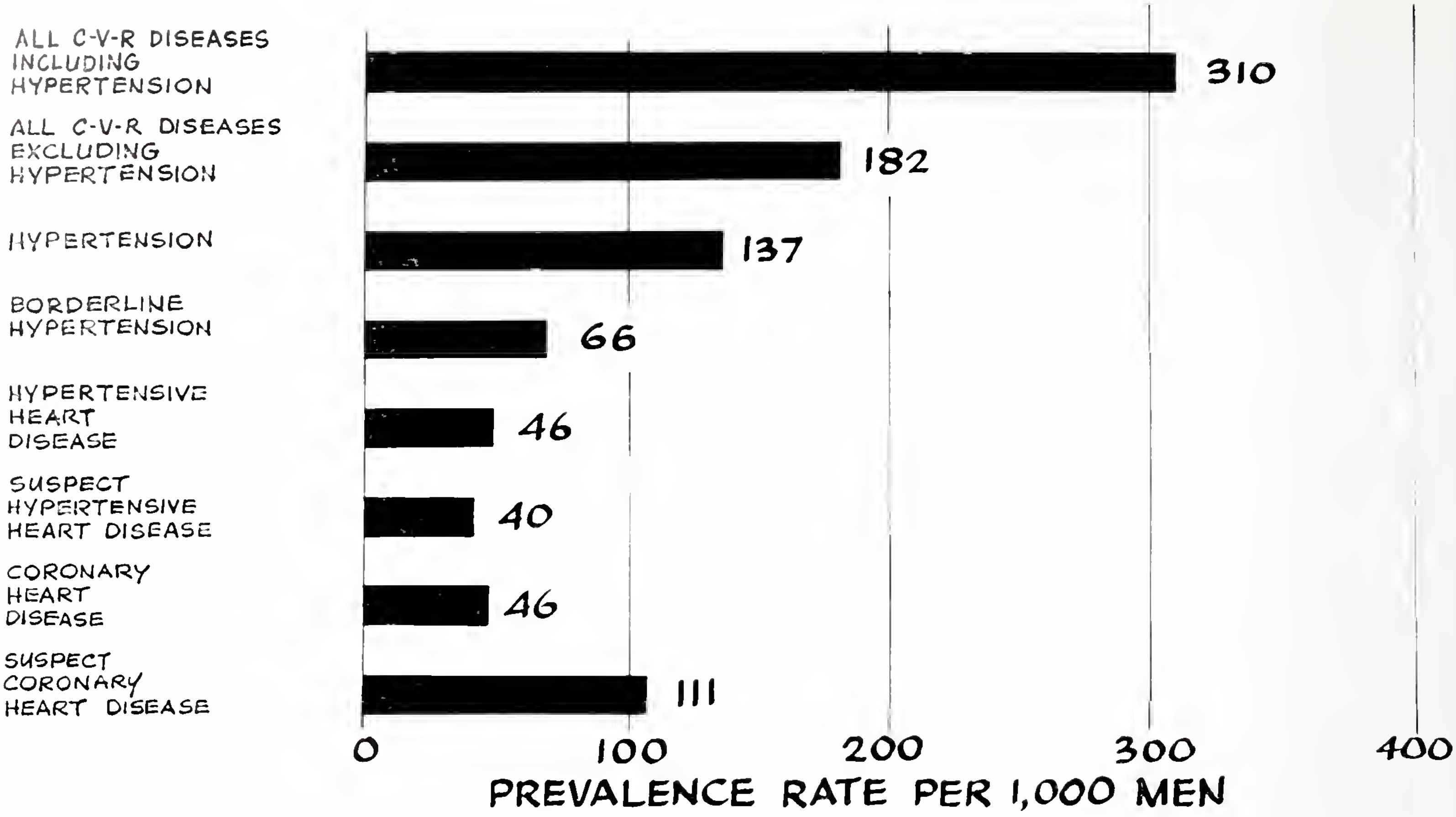


FIGURE 1

Prevalence of Cardiovascular-Renal Diseases in the 1465 men age 40-59 in the Peoples Gas Light and Coke Company labor force, 1958.

group during the intervening years. Data analyzed to date indicate that the 40 month incidence rate of new coronary disease was in the order 35 per 1000 men or about 11/1000/year. With simple arithmetic, it is possible to arrive at the approximation that the average presently healthy middle-aged American male, free of clinical coronary disease (insofar as can be determined with our present diagnostic methods), has about one chance in five of developing this disease in middle-age, that is, before age 65. This is indeed a rather high average risk.

An incidence rate of about 10-15 per thousand per year is fairly uniformly experienced by all sub-groups in our middle-aged urban male population—by Negro and white men; indoor and outdoor workers; men doing sed ntary or light or medium activity work; white and blue collar workers (with a statistical hint that the blue collar semi-skilled, unskilled and service workers may be a little better off, but not remarkably so). Contrary to earlier misconceptions, the recent studies in representative large samples of the living population have yielded solid consistent data showing that the toll being exacted by coronary disease is falling heavily upon all socioeconomic and ethnic strata. This disease is by no means confined to the managerial, executive, supervisory groups. It is indeed "epidemic," to use Dr. Paul Dudley White's term, throughout our middle-aged male population.

Figure 2 illustrates a further important characteristic of this disease. These are data recently presented at the Fourth World Cardiological Congress in Mexico City. They are based on several years of follow-up by the Public Health Service Study of more than 5,000 men and women in Framingham, Massachusetts. They document a particularly pernicious aspect of the coronary disease problem. Our studies of the Gas Company men have yielded like findings. In the 5,000 Framingham men and women, originally free of coronary disease, 242 developed the disease over time. Of the 242, 83 (34%) died within 3 weeks of becoming ill; 46 (19%) experienced sudden death, occurring within one hour, that is within such a short time as virtually to preclude their receiving any medical care whatsoever. These facts deserve emphasis, because they compel an important conclusion: If effective progress is to be made against this disease, if a real breakthrough is to be achieved, a significant lowering of its impact, at least in middle age (as a first objective), then of necessity—in view of the high rate of sudden death—the focus of the effort must be on primary prevention. That is the prevention of the first attack! As important as it is to improve therapy during the acute attack (for those surviving long enough to receive medical care), as important as it is to improve long-term therapy for those who fully recover from an acute attack—and the importance of these cannot be overestimated—the major emphasis must be on primary prevention.

The validity of this conclusion is driven home by an additional set of related facts: Those who recover from an acute episode of coronary disease in middle age have a subsequent mortality risk several times greater than the general population of age-sex-matched individuals. Data demonstrating this phenomenon have been repeatedly collected in life insurance company studies, as well as in prospective epidemiological and longterm clinical investigations. Data from the Gas Company study and the placebo group in our longterm evaluation of estrogen therapy fully confirm these findings (Figs. 3 and 4).

All these facts—about the high mortality rate with acute first attacks of myocardial infarction and the impaired longterm prognosis of those fortunate enough to recover from the immediate onslaught of the disease—serve to focus the spotlight on the foremost present-day challenge: Is it possible—is the knowledge available—to accomplish primary prevention of premature clinical coronary disease? That is, can first attacks be prevented at age 40, 50 or 60?

This article will be concluded in the December Issue of ALASKA MEDICINE

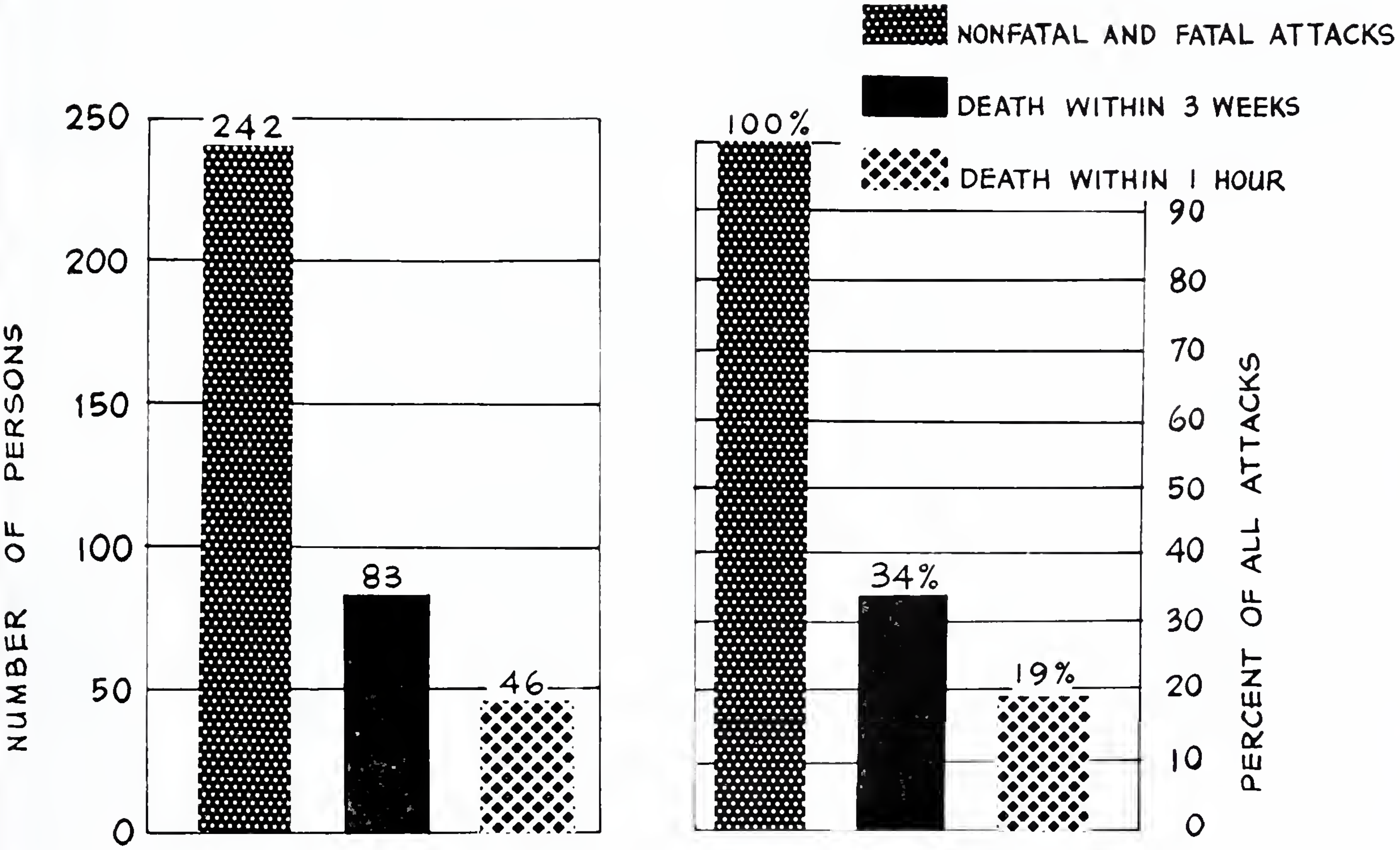


FIGURE 2

Immediate mortality in heart attacks among 5128 men and women age 30-62 at the onset of the Framingham prospective epidemiologic study—eight year follow-up data.

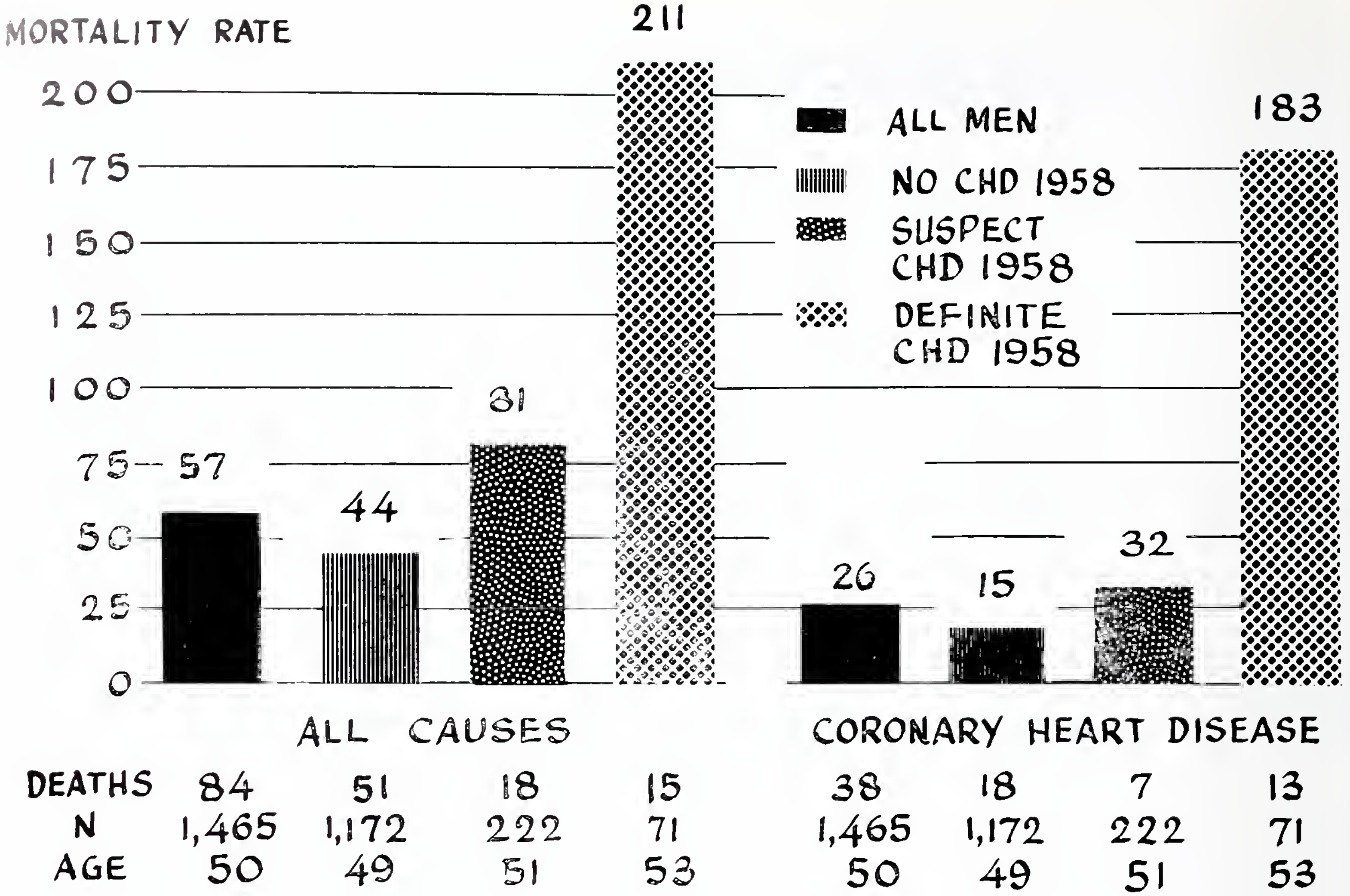


FIGURE 3

Relationship between diagnostic status with respect to Coronary Heart Disease in 1958 and subsequent mortality—Peoples Gas Light and Coke Company Study, men orginally age 40-59, January 1, 1958, through October 31, 1963.

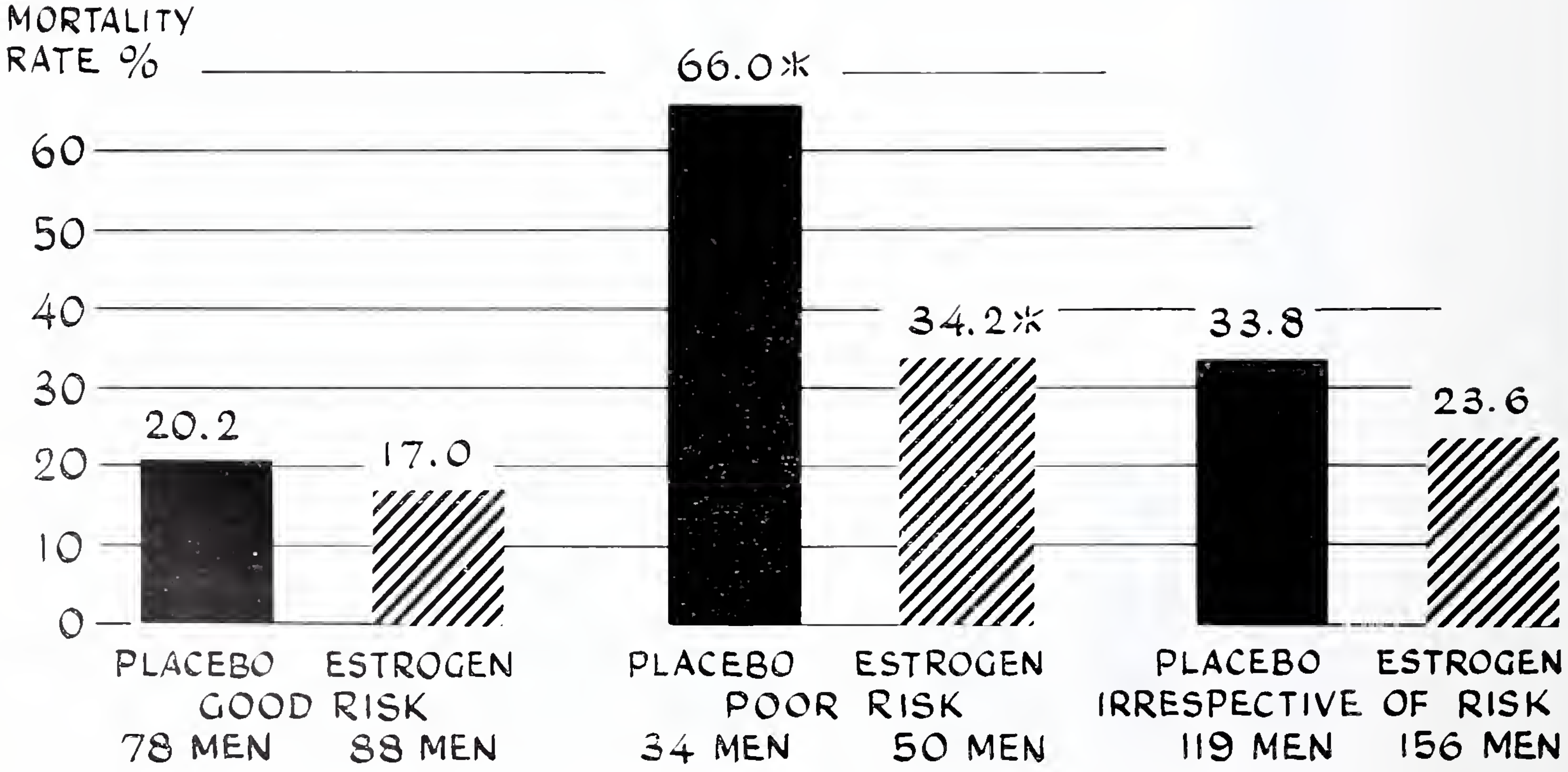


FIGURE 4

Five-year mortality rate in men with a history of previous Myocardial Infarction prior to the age of 50. Good risk men are those with a single previous myocardial infarction uncomplicated by other major diseases or by friction rub, arrhythmia, shock, congestive heart failure or extension of the infarct during the acute episode; poor risk men are those with two or more previous myocardial infarctions, or men with other major diseases, or men with a single previous myocardial infarction complicated by friction rub, arrhythmia, shock, congestive failure or extension of the infarct during the acute episode.

SHEEHAN'S SYNDROME: A Case Report

F. JAY KEEFER, M.D.

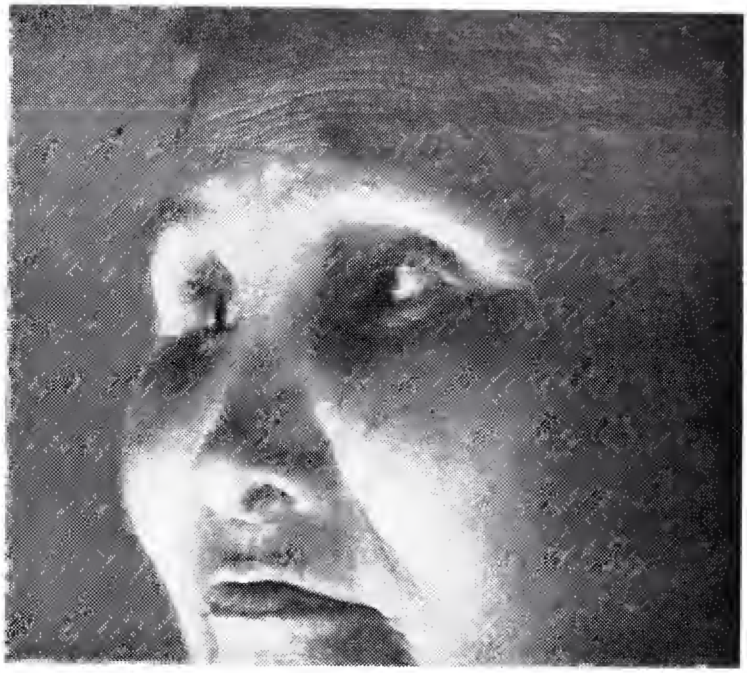
United States Public Health Service Hospital, Bethel, Alaska

Sheehan's syndrome (postpartum necrosis of the pituitary with hypopituitarism) is a well-defined clinical entity accounting for most of the cases of non-neoplastic spontaneous hypopituitarism. Postpartum hemorrhage, with its attendant shock or prolonged hypotension, is felt to be the cause of this necrosis in most cases.

The number of deliveries occurring in the remote areas of Alaska unattended by a professional person is decreasing. However, because of isolation, problems of transportation and custom, such deliveries have been common in the past and continue to a lesser extent. Inevitably some of these women suffer from excessive hemorrhage and hypotension. As might be anticipated, some of these will later develop the features of spontaneous hypopituitarism. An illustrative case is presented.

CASE REPORT: On March 3, 1963, a 36 year old Eskimo lady was admitted to the Bethel Alaska Native Hospital accompanied by her two daughters, who were the original historians, as the patient was confused. Her illness started about two weeks prior to admission with earache and headache. Shortly thereafter, she experienced paroxysms of weakness, stiffness of the muscles, clouding of her sensorium, nausea and vomiting. She reportedly vomited on numerous occasions prior to admission. Upon arising from bed, she would get dizzy, nauseated and vomit. A few days prior to admission, she developed "muscle twitching", and her condition had become progressively worse.

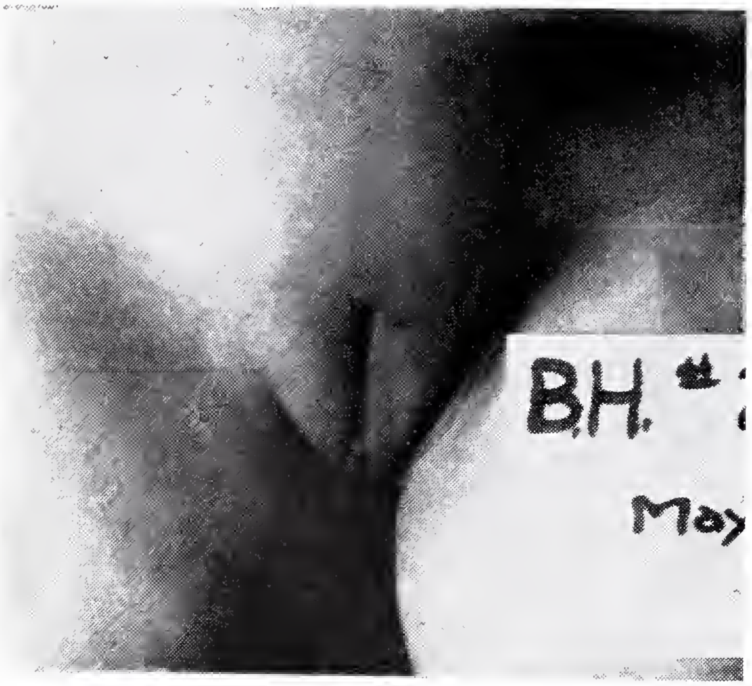
The patient was a Gravida IV, Para IV, Abortus 0, whose last normal menstrual period was before the birth of her last child in about 1954. The infant died in the neonatal period. The patient bled rather severely immediately postpartum. She recovered from this severe bleeding rather slowly, with resulting complaints of weakness and easy fatigability. She was seen in the Bethel Hospital Outpatient Clinic on several occasions with complaints of weakness, blurry vision, aching of the arms and legs. She was noted to be thin and pale. Her only previous admission was in 1956 for acute tonsillitis. At that time, she reported amenorrhea for approximately one to two years. A differential blood count at that time revealed 12% eosinophilia. No other significant findings were recorded from her only admission or from her outpatient visits, except for the pallor and the thin appearance.



Picture demonstrating typical faces with sunken eyes.

Physical examination at the time of admission, 3-4-63, revealed a very weak, thin Eskimo lady with sunken eyes and a sallow color. Her blood pressure was 110/80, pulse 100. Her skin was warm, dry and pale. There was no pubic or axillary hair or excessive pigmentation. The buccal mucosa was pale pink, with no excessive pigmentation. The eye grounds were normal, as were the pupils. The thyroid gland was not palpable. The chest was normal to percussion and auscultation. Auscultation of the heart revealed a split P_2. The abdomen was normal except for voluntary guarding in the epigastric region. Bowel sounds were normal. The labia majora and minora were atrophic. The vagina was small, almost atrophic, as were the cervix and uterus. The adnexa could not be felt. The neurological examination revealed cranial nerves intact, no obvious muscle weakness, sensation to pin prick present and equal bilaterally but deep tendon reflexes could not be elicited.

Spinal tap done prior to admission revealed no cells and a protein of 29 mg.%. Admission CBC was 13,650 with a differential of 75% neutrophils, 22% lymphocytes, 3% eosinophils and hematocrit was 35%. An I.V. was started because of an apparent dehydration and history of gastrointestinal upset. Shortly after admission, her blood pressure fell to 80/60 and the patient was treated with Aramine (Metaraminol), 2 cc. I.M. This resulted in a rising of the pressure to normal levels. Three hours later, her blood pressure fell again to 70/50. The patient was confused at this time. Aramine was added to the IV fluids. There was no evidence of bleeding and the cause of her hypotension was obscure. The picture appeared to be that of an adrenal crisis, since no other reason for shock could be established. Hydrocortisone was added to the IV and saline was given at 120 cc. per hour. This resulted in a low normal pressure. A repeat dose of Hydrocortisone was given six hours later until the patient was transferred to the Anchorage Alaska Native Service Hospital.



Picture showing lack of pubic hair.

The patient was semi-comatose and confused throughout most of her one day hospitalization at Bethel. A provisional diagnosis of adrenal crisis secondary to panhypopituitary deficiency due to post partum hemorrhage (Sheehan's Syndrome) was made.

On admission to the Anchorage Hospital, the patient appeared pale and semicomatose with cool, dry skin. She had an intravenous infusion of 1,000 cc. of 5% Dextrose and water with Aramine running.

The initial laboratory values showed her hemoglobin to be 10.5 gm.%; serum sodium, 135 mEq/1; serium potassium, 4.6 mEq/1; chloride, 103 mEq/1, and CO_2, 15 mEq/1. Initial blood sugar was 390 mg.%, and the urinalysis showed 4 plus glycosuria with moderate amount of acetone. Twenty-five units of regular insulin was given intravenously, and twenty-five units were given subcutaneously. No more insulin was given during her course in the hospital. Her blood sugar gradually came down, and by noon the next day she was somewhat hypoglycemic. The 24 hour urine test for 17 ketogenic steroids obtained on the third hospital day was 13 mg./24 hours. This value was thought to be high because of the Solucortef she had received in the preceeding 72 hours. Two protein bound iodine determinations were obtained, both were in the low normal range of 4.2 and 4.3 mcg.%. A radioactive iodine uptake was obtained, and this was 3% in 24 hours on the initial study, and after three days of TSH stimulation, the radioactive iodine uptake increased to 14%. Her serum calcium, phosphorus, SGPT and BUN all were within normal limits. Serum cholesterol was 300 mg.%. Glucose tolerance tests done on 3-12-63 and 4-12-63 were both abnormal with normal fasting levels but two hour levels of 160 mg.% and 190 mg. %. Glycosuria was not found during either test. Aramine was continued until it could be gradually withdrawn on the third hospital day. There was a rise in the urinary 17 Ketogenic steroids from 2.1 mg./L. the day before the ACTH stimulation to 3.8 mg./L. on the third day of ACTH stimulation suggesting, but not proving adrenal response. A

Methopyrapone Test showed no rise in the 17 Ketogenic steroids from 4.9 mg./24 hours after the intravenous injection of Methopyrapone.

Smears of the vaginal and cervical mucosa revealed atrophic changes to a moderate degree.

Because of the evidence of decreased thyroid and adrenal function along with increase in the thyroid function after thyrotropin stimulation, the diagnosis of Sheehan's Syndrome seemed to be substantiated, and the patient was given desiccated thyroid in increasing dosages up to 1½ gr. daily at the time of discharge along with hydrocortisone, 20 mg. daily.

DISCUSSION: Panhypopituitary deficiency as a result of pituitary necrosis secondary to severe postpartum hemorrhage is an illness that is easily overlooked. Sheehan feels that over 50% of those patients with severe postpartum hemorrhage and shock develop some degree of pituitary deficiency. Any patient with severe postpartum bleeding and shock should be followed carefully for several years for signs of panhypopituitary deficiency. Likewise, any patient with history of severe postpartum hemorrhage should be thoroughly examined for this condition. The symptoms of Sheehan's Disease are listed as follows:

1. Amenorrhea, following the birth of the last child. This also could be decreased menstrual flow.
2. Failure to lactate in the postpartum period.
3. Anorexia and vomiting in any stressful situation.
4. Weakness and fainting spells under stress.
5. Loss of ambition and interest in surroundings.

The signs of Sheehan's Syndrome are as follows:

1. Pallor of the skin.
2. Loss of axillary and pubic hair.
3. Thinning of the eyebrows.
4. Atrophy of the breasts.
5. Atrophy of the genitalia.
6. Signs of electrolyte imbalance.

Helpful laboratory studies in the diagnosis of Sheehan's Disease:

1. Vaginal smear which reveals atrophic vaginal mucosa.
2. Endometrial biopsy which reveals scanty and atrophic tissue.
3. Urinary FSH shows low or absent level.
4. Thyroid studies all show hypofunction with low levels.
5. Serum cholesterol elevated, in some cases.
6. Highly labile blood sugar levels.
7. Adrenal cortical function studies show low levels.

In summary, this is a report of a woman who suffered with undiagnosed panhypopituitary deficiency for several years without detection or treatment. The diagnosis was made only in the face of an acute crisis.

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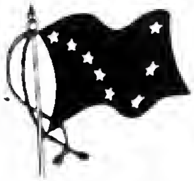

IN MEMORIAM

A. HOLMES JOHNSON, M.D.

Dr. A. Holmes Johnson, physician, surgeon and community leader, died August 21, 1964, at his home, Sprucehaven, Kodiak, Alaska. He died at the age of sixty-nine, as he had lived, with courage and dignity. His fellow physicians knew him as a quiet and extremely capable physician, who first came to Kodiak from Portland, Oregon in 1938. He practiced there continuously until 1960, after which his medical endeavors were limited to special surgical problems and consultation in the Kodiak area. From his retirement until his death, Dr. Johnson was busy in community affairs, with much time and effort spent as District Governor, Rotary International of Washington, Canada and Alaska area.

Dr. Johnson, the son of a Bishop of the Methodist church, was born 18 October, 1894 at Mapleton, Iowa. He was a member of the Iowa National Guard from 1912 to 1916, serving on the Mexican border in 1916. He saw service as a lieutenant, tank corps, American Expeditionary Force, 1918 through 1919, and was a member of the United States Army Medical Reserve Corps from 1924 through 1940. Prior to entering college and embarking on his medical career he was editor and printer of the North Douglas **Herald,** Drain, Oregon in 1914. He graduated from Morningside College, Sioux City, Iowa with a BA degree in 1918, received a Bachelor of Science degree from the University of Oregon in 1919, and his doctorate in medicine from Northwestern University in Chicago in 1924. His postgraduate studies included work at Oxford University, England.

Dr. A. Holmes Johnson

For five years he practiced general medicine in St. Helens, Oregon, and for eight years resided in Portland, Oregon, limiting his practice to general surgery. In 1929 to 1934 he was the clinical instructor of surgery at the University of Oregon Medical School, and a member of the surgical teaching staff at Multnomah County Hospital for that same period.

In 1938 he moved to Alaska and has been prominent in medical and community affairs in the state. In 1947 Dr. Johnson was elected President of the Alaska State Medical Association, and at the last State Medical Association meeting in Ketchikan, May 30, 1964, he was recognized with the Robbins Community Service award.

His community service has included being President of the Kodiak Rotary Club, on three occasions, District Governor of Rotary International, President of the Kodiak School Board and Public Library Board, and a member of the Kodiak Planning and Zoning Commission. Before coming to Alaska he was President of the St. Helens, Oregon Chamber of Commerce, medical director of the Oregon Y.M.C.A. camps, and chairman of the Northwest area Physical Education Committee, Y.M.C.A. A small boat enthusiast, he was Commodore of the Portland Yacht Club, and President of the Columbia River Yachting Association.

Dr. Johnson served as Chairman of the Civil Defense in Hospital Units in his area in World

War II, was a director of the Bank of Kodiak, President of the Kodiak Community Center Board 1945 through 1950, President of the Kodiak and Aleutian Islands Historical Society 1954, President of the Kodiak Library Association from 1951, President of the Association of Alaska School Boards in 1958 and President of the Kodiak Council of the Navy League in 1960.

He was a Fellow of the American College of Surgeons, a Fellow of the American College of Chest Physicians, and a Governor of Alaska for the College of Chest Physicians. He was a member as well as official delegate from Alaska to the Pan Pacific Surgical Association, a Fellow of the American Society of Abdominal Surgeons, and the author of three scientific papers: "Great Omentum and Omental Thrombosis"; "A General View of Tuberculosis in Alaska"; and "Treatment of Acute Cholecystitis".

Dr. Johnson is survived by his wife, Fostina; his son, Robert, practicing in Kodiak; his mother, Mrs. Eben S. Johnson, a resident of Portland; his brother, Darlow Johnson; and a sister, residing in Capetown, South Africa.

Those of us who visited him during his illness, an illness from which he knew there was no recovery, were impressed as always with his dignity and personal command over his own situation. He lived by a personal credo, and has left that credo for us. With permission of his son this is printed for this is how he lived.

William J. Mills Jr., M.D.

PERSONAL CREDO

I believe in God as the Ultimate Reality behind the perfect order in the macrocosm and microcosm of the Universe, who cannot be imagined nor described by our finite minds, and that any attempt to do so would be a frustrating waste of time.

I believe that there is good in all religions, and that the uninterpreted teachings of Jesus give us one of the best guides for daily living.

I do not know if there is a life after death, nor am I concerned about it. I believe that, if one honestly lives up to the best of his knowledge, he has no need for worry about the hereafter.

I believe that "sin" may be defined as any act which may harm any person, physically, mentally or spiritually.

I believe that our duty in life is to perfect ourselves and do good to others, to help where help is needed, to continually search for the truth, and to always strive for and express the good, the true and the beautiful.

A. HOLMES JOHNSON, M.D.

President's Page . . .

Dr. Joseph P. Deisher

FAUT DE MIEUX

That's how the Alaska State Medical Association got its president this year—**faut de mieux**—for lack of something better. But we'll do what we can and it may not end up too badly . . . if we all do what we can. **Faut de mieux** might be said of the republican, democratic, free enterprise capitalistic system too. Winston Churchill once indicated that it was really a very unsatisfactory system, but there isn't anything better.

One of the efforts to change our present system is in the proposed 1964 amendments to the Social Security Act. One of the provisions is COMPULSORY inclusion of physicians and other self-employed persons under the bankrupt Social Security System. THIS WILL COST YOU ABOUT $300 A YEAR right now. Another interesting thing is that THE COST WILL GO EVEN HIGHER by 1970. If this proposal becomes law you won't be able to DO ONE DAMN THING ABOUT IT but pay up. An ounce of prevention is the ONLY cure!

At the 1964 San Francisco meeting the AMA went on record with a milktoast resolution to the effect that every physician had a right to do as he pleased with his income as long as he abided by the law. Trouble is the law keeps changing, keeps reaching deeper into your pocket to give you more benefits. That may not be the way you want it, but that's how it will be—FAUT DE MIEUX—unless the physicians of the U.S.A. take a concerted action to let our legislators know what we want. We have to be very expressive about where the mainstream of our philosophy lies.

The program, the activities, the "public image" of the Alaska State Medical Association is what it is FAUT DE MIEUX, for lack of something better. In this Great Land of Alaska, in this great land of America, the distances between us and our leaders are long from place to place and from mind to mind. We—each of us—must learn to communicate with each other. Illiterate as we doctors are we can write what we think—if we get riled up enough.

A new program entitled "LETTERS TO LEGISLATORS" would be a very good thing. This goes for State Legislators, U.S. Congressmen and Senators, officers of the ASMA. Don't sit around and bitch over your beer. Write it down! Fire it off in Mr. Gronousky's mail bags! If you can't write, dictate it to your wife. It is important to her and the kids. They are going to outlive you anyway. They get the benefits of your Social Security provided they have an income under $100 a month. And the kids get the tax burden later. Probably be good for 'em—gives 'em a sense of responsibility—FAUT DE MIEUX, that is. FOR LACK OF SOMETHING BETTER.

"All that is required for evil to triumph, is that good men do nothing," said Edmund Burke, and it doesn't get said any MIEUX than that!

ADDENDUM

WARNING! Don't look upon the "shelving" of Medicare as an occasion for joy. Check the strategic plan! Watch for vote-coercing move to tack King-Anderson on to the Social Security bill as an amendment. Or amendments to liberalize Kerr-Mills provisions far beyond those of King-Anderson. . . Congress respects your views if their number is great enough. Legislators do not see the light; they feel the heat. Get HOT! Write the Alaska Ambassadors to Washington YOUR VIEWS. Otherwise how will they know?

LETTER TO A SENATOR

Senator Harry F. Byrd,
Chairman, Senate Finance Committee,

Physicians throughout the country have for many years opposed their compulsory inclusion under the Social Security Taxation System. The majority of physicians continue to oppose this inclusion. As President of the Alaska State Medical Association I request that you do all in your power to remove the provision from the Social Security amendments of 1964 which compulsorily includes physicians under this tax-and-dole program.

Alaskan physicians feel that compulsory inclusion of physicians under the Social Security Taxation System would be grossly unfair for the following reasons. Each physician would be required to contribute the percentage set by law on the first $5400 of his income. This would go on with each year that went by and the percentage would be increased as would, if past experience is a good teacher, the base on which the tax was calculated. Only seldom does the physician really retire before he is 70 or more years old. This means that only the rare physician has any likelihood of receiving any return on this taxation (sometimes miscalled "insurance") because of continuation of his income above $1200 per annum even though he limits himself to part time work. Herein lies the chicanery in the Social Security plan for any professional person. The same amount of money invested privately in an annuity program will supply him with a basic income which will permit his cutting down his practice as he reaches his later years even though he does not completely discontinue it.

It is recognized that as a strategic ploy the inclusion of physicians under the Social Security System weakens their position in holding out against a socialized system of medicine and health care. Even though only a few doctors are in a position to receive Social Security benefits, this fact can be exaggerated in the debate before the American people to point out that doctors although fighting for a free medical system are accepting some help from the Social Security plan. You are fully aware, I am sure, of how this can be used by those who would persuade the lay public that the doctor's fight for a free medical system is a selfish one.

Again, Senator Byrd, let me, on behalf of the physicians of Alaska, urge you to use your influence to prevent this compulsory inclusion of physicians under the Social Security Taxation system.

J. B. Deisher, M.D. President

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1965
ASMA CONVENTION
PLACE
University of Alaska
College, Alaska
DATES
May 26, 27, 28, 29, 1965

KETCHIKAN

Alaska State Medical Association Convention

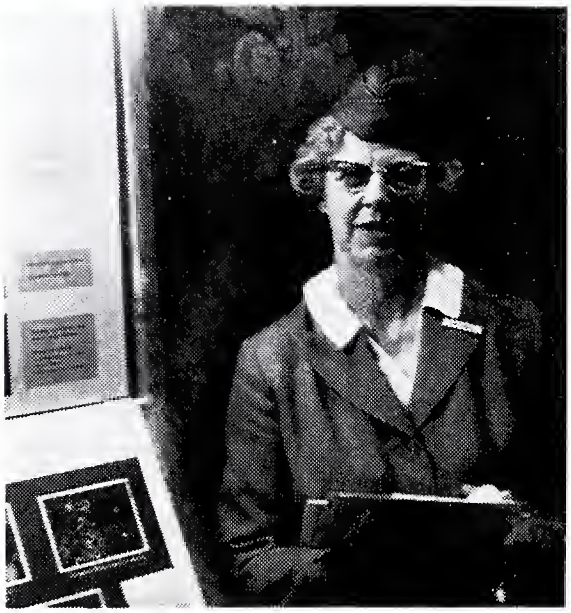
Incoming President
Dr. Joseph B. Deisher (lt)

Outgoing President
D.. Ralph W. Carr (right)

New Speakers

Left, Dr. Raldolph Lovelace

Right, Dr. George Pack



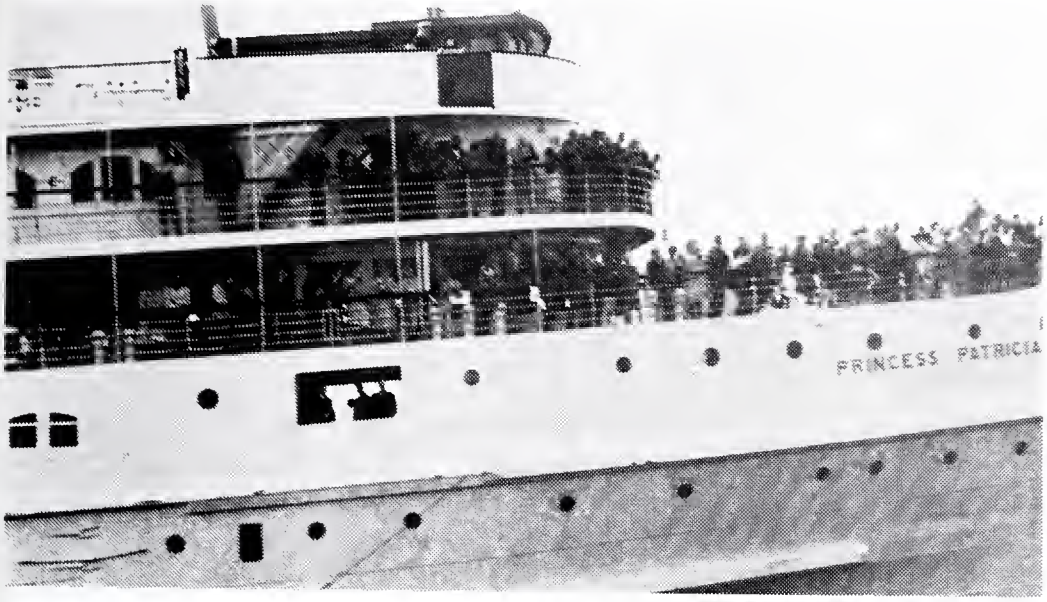
Old Standbys

Left, Secretaries
Vivian Ayerst and
Dr. Robert Wilkins

Right, Public Health Nurse,
Mary Rowley

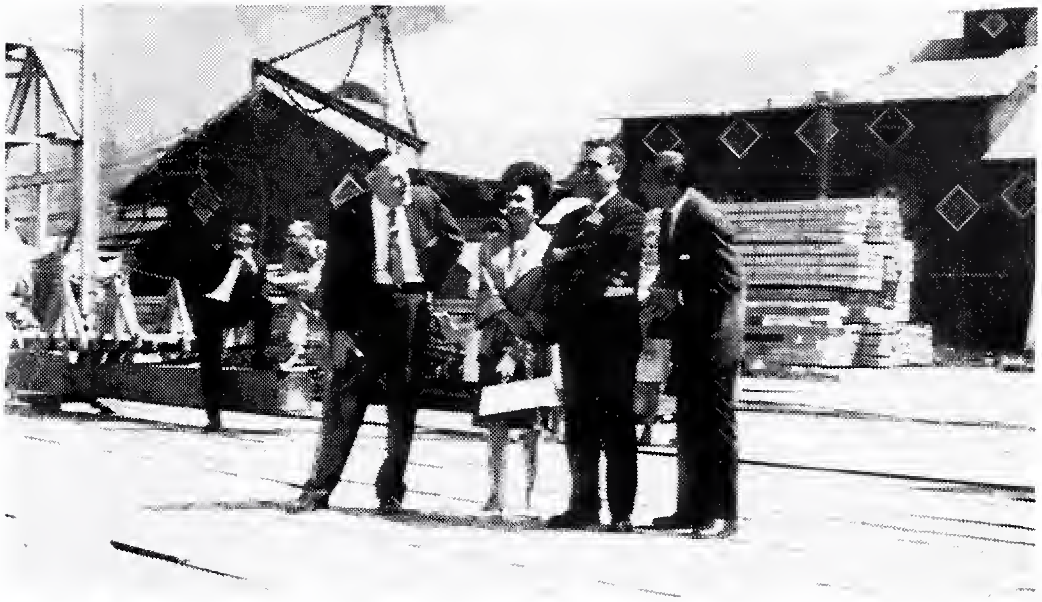
HIGHLIGHTS

Ketchikan, May 27-30, 1964



150 couples from the British Columbia Association of General Pratice

. . . are greeted by Dr. Ralph W. Carr, ASMA President,



. . . and the Metlakatla High School Band.

Editorial Page . . .

"BATTERED CHILD" LEGISLATION

The actual numerical significance of the "Battered Child Syndrome" in a new state such as Alaska with its extremely youthful population (the average population age has dropped recently from 26 to 24 years); with its many transients seeking a solution to their problems on "the last frontier"; and with its large native population who have a culture in transition, has not been determined. Certainly there has been an increased awareness and reporting of such cases. There has been considerable publicity given to the Children's Bureau's recommendation that mandatory reporting bills be passed by states to insure referral of such cases to official enforcement agencies. A law meeting these criteria was submitted at the last legislature but did not pass. Objections raised included the following: 1. The use of the word "mandatory reporting," which caused concern by some that this would be an infringement on the parents' rights in case of false reporting of such children, and the possibility of over reporting by a physician, even if he were not absolutely sure that the child had been physically abused because of the misdemeanor clause; 2. Considerable concern was expressed that the proposed law required reporting to a police agency, which would preclude therapy for families which could be rehabilitated; 3. The physician was not protected from action alleging slander or libel when such families are reported.

Both New York and Massachusetts have recently passed laws to protect children under the age of 16 years who can be reasonably suspected of being victims of physical injury or abuse. Such cases are to be reported to each states' Department of Public Welfare. It is then the responsibility of the Welfare Department to investigate the case and to take appropriate action, in addition to maintaining a registry of these cases. These laws also provide additional funding to the Department of Welfare to provide such service. The law absolves the reporting physician from liability action. The necessary additional funds are vital if such a bill is to be effective, as the Department of Health and Welfare repeatedly has had its budget cut with a resulting reduction of personnel. It would be anticipated that in the long run considerable money would be saved in foster home care, court trials, prison sentences, etc., to say nothing of the possible crippling or loss of life that might be prevented by early appropriate investigation.

It would seem appropriate before the next legislature meets and before another unsatisfactory law is introduced, for interested members of the medical profession to express their opinion on this matter to their elected and about to be elected representatives in order to achieve the desired results.

COMMUNITY HEALTH WEEK

The week of October 18 to 24 has been designated "Community Health Week" by the American Medical Association. In keeping with the nationwide program the Alaska State Medical Association is planning to call attention to medical progress made and health facilities available throughout the state.

Through the public information committee recently appointed by Dr. Joseph Diesher, ASMA president, information will be made available to all major newspapers, radio and television stations. Members of the committee include Dr. Elizabeeth Tower, chairman; Dr. Winthrop Fish; Dr. Milo Fritz; and Dr. William Whitehead.

The program, as planned by the AMA, includes teaming up with various agencies in presenting information on general public health such as sanitation; local, state, and federal health services; voluntary agencies; immunization; accident prevention; physical fitness (diet, exercise, recreation); hospitals and clinics; medical and dental services; and others.

Obviously it is impossible for the committee to obtain all the information on health facilities available in each community. Therefore, it is urged that a committee or individual physician in each community contact all the news media in that area and enlist their cooperation in publicizing what the community had to offer 10, 15, or 50 years ago, and what it has now, and expects for the future.

It's also good public relations to let people know that local doctors are affiliated as acting physicians or consultants under contract with the many agencies supported by the taxpayers. You might also mention the many hours doctors give voluntarily and freely as board members or advisors on community projects; and their sponsorship of other programs for the betterment of medical practice in general.

U. S. P. H. S. News

U.S. SURGEON GENERAL VISITS ALASKA

For the first time since his appointment as Surgeon General of the Public Health Service, Dr. Luther L. Terry visited a number of PHS installations in Alaska the latter part of May.

He began his nine-day tour in the southeastern section on May 17, stopping first at Annette Island to see the new field clinics at the Coast Guard Air Attachment base and the Indian village at Metlakatla, and next at the 200-bed hospital for both tuberculosis and general patients at Mount Edgecumbe.

At Juneau he addressed a large group of private and Governmental physicians and other health personnel at a luncheon meeting, conferred with Governor William A. Egan, Dr. Levi Browning, Health and Welfare Commissioner, and Admiral George Synon, Commander of the 17th U.S. Coast Guard District, and visited the PHS field health center.

In Anchorage he inspected earthquake damage to the PHS Alaska Native Hospital and Arctic Health Research Center, met with military and medical leaders at Elmendorf Air Force Base, and addressed a combined meeting of the medical and dental societies.

Dr. Terry flew to Barrow to look at the present 12-bed Alaska Native Hospital and review progress on ground preparation for construction of a new hospital, and to visit the Arctic Research Laboratory co-sponsored by the U.S. Navy and University of Alaska.

In Fairbanks, he met with the University Regents and broke ground for two new PHS buildings—a Water Pollution Control Laboratory and Arctic Health Research Center.

On Monday, May 25, he spoke at the Commencement ceremonies of the University and was awarded an Honorary Doctor of Laws degree.

ADVISORY COMMITTEES VISIT

Under Public Health Service auspices, two national advisory committees met in Anchorage in mid-August to review the PHS health program for Alaska Natives (Indians, Eskimos and Aleuts). One committee is advisory to the Surgeon General on PHS hospitals and clinics; the other advises the American Dental Association on Federal dental services.

The committees visited Bethel and Mekoryuk (Nunivak Island) to observe the Eskimos' living conditions and the methods by which PHS doctors, dentists, nurses, sanitary engineers and others work with the Native people to help them better their environment, health habits and general state of health.

In Bethel they studied operations of the PHS Native Hospital and monitored a medical radio clinic conducted daily by PHS hospitals for Alaskan villages with which the only contact is short wave communication. Each day a physician talks to a trained native aide who reports on conditions needing medical advice and then prescribes the care or treatment indicated. When hospitalization is necessary, the physician arranges air transportation for the patient.

In Mekoryuk they inspected a community water system just completed through a cooperative effort between PHS and the villagers so the people will have pure water to use for the first time, and saw how medical teams and village aides conduct clinic services on the island.

In Anchorage the committee reviewed operations of the 400-bed Native Hospital which has a complement of specialists able to treat more complicated medical cases than can the smaller PHS Alaskan hospitals at Bethel, Kanakanak, Kotzebue, Tanana and Barrow. Occasional cases also are referred from the Mt. Edgecumbe Hospital.

Members of the team included: Drs. Leo L. Gehrig. Carruth J. Wagner and E. S. Rabeau, from the Central Division of Indian Health Staff and the following consultants: Dr. K. Alvin Merendino, Seattle, Wash., Surgery; Dr. Harold Jeghers, Jersey City, N.J., Medicine; Miss Helen W. Dunn, Chicago, Ill., Nursing; Dr. Charles A. McCallum, Birmingham, Ala., Dentistry; Dr. Robert Stubblefield, Dallas, Texas, Psychiatry; Dr. William A. Meissner, Boston, Mass., Pathology.

1964-65 STAFF

ANCHORAGE AREA OFFICE

Dr. Holman R. Wherritt continues as Area Director. Dr. Enrico Leopardi, Deputy Area Director, arrived from Billings, Montana. Dr. Harriett Jones, previously with the Philadelphia Department of Health, is Program Planning Officer.

ANCHORAGE HOSPITAL

As is usual on July 1, 1964 there were some changes in the medical staff. However, this was less than in most previous years and there were no changes in the Chiefs of Service. Several physicians were transferred to Field Hospitals after a years experience at the Anchorage Medical Center. Dr. Martha Wilson continues as Medical Officer in charge of the hospital and Service Unit Director. Dr. Joseph Wilson is Chief of Surgery with Dr. David Dolese as Deputy Chief and Dr. Albert Diddams as Assistant Chief. Chief of Medicine is Dr. Walter Johnson with Dr. Shirley Fraser as Assistant Chief. (Shirley's husband, Dr. Robert Fraser, is in charge of Tuberculosis Control for the State.) Dr. Richard Chao is Assistant Chief of Medicine in charge of tuberculosis. The Pediatric Service is headed by Dr. George Sperry. Other physicians continuing in their respective specialties include: Dr. Gilbert Wright, Orthopedics; Dr. Leslie Thomasson, ENT; Dr. William Buchanan, Opthalmology; Dr. Evanglos Trahos, Radiology. In charge of the Outpatient Department is Dr. Gloria Park. Other physicians on the Anchorage Hospital staff include: Dr. George Brenneman, Thomas Corbett, David Dixon, Donald Huber, Charles Hudson, Richard Light, James Mize, Robert Russell and Milton von Minden.

BETHEL

Dr. Robert Fortuine who was SUD at the Kanakanak Hospital last year is now in charge of the Bethel Hospital. Other physicians at the Bethel Hospital are: Drs. Paul Davidson, Daniel O'Connell and Eugene Trout.

KANAKANAK

Dr. Carl Denny who was at Bethel last year is SUD and is assisted by Dr. Thomas Moylan.

PT. BARROW

Dr. Glenn Hisrich, who was on the staff at the Anchorage Hospital last year, comprises the entire medical staff at Barrow.

ST. PAUL ISLAND

Dr. Arthur Colberg is continuing at St. Paul.

KOTZEBUE

Dr. Charles Neilson who had previously served at Kotzebue, returned as SUD. On his staff are Drs. Frederick Banfield and William Compton.

TANANA

Tanana has two physicians new to Alaska, Dr. Donald Lorentzen, SUD and Dr. Harley Miller.

MT. EDGECUMBE

Dr. George Wagnon who was previously in charge of the Kanakanak and Bethel Hospital continues as SUD at Mt. Edgecumbe. His staff includes Dr. Will Nash, Clinical Director, Dr. George Hubert, Chief of Medicine, Dr. George Longenbaugh, Chief of Surgery, Dr. Richard Paul, Pediatrician, and Dr. Charles Chapman, OPD. Other staff members are: Dr. J. Paul Lunas, in charge of tuberculosis, Dr. Gordon Benner and Dr. Robert Manck.

Dr. James Justice is field physician for Southeastern Alaska.

PHS CLINICS

Juneau—Dr. Robert L. Schmitt.
Annette Island—Dr. Roger Bauman.
Metlakatla—Dr. James Brubaker.

Announcement

CLINICAL CENTER STUDY OF CHRONIC MYELOGENOUS LEUKEMIA

The cooperation of physicians is requested in a continuing study of chronic myelogenous leukemia being conducted by the Medical Service of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Referrals of patients with chronic myelogenous leukemia are needed. Particularly needed are those in the 20 to 40 year age group with high white blood cell counts and platelet counts, for studies of newer chemotherapeutic agents and as a source of white cells and platelets for **in vitro** and **in vivo** study.

Physicians who wish to have their patients considered for the study may write or telephone:

Dr. Paul P. Carbone
Clinical Center, Room 10-N-106
National Institute of Health
Bethesda, Maryland 20014
Telephone 496-4251 (Area Code 301)

MUKTUK MORSELS

A Column Devoted to
Medical News in Alaska

Compiled by

HELEN S. WHALEY, M.D.

GENERAL: During the first week in September, the Alaska Heart Association held its seventh annual heart clinic in co-operation with the Alaska State Department of Health and Welfare and the Alaska Native Health Service. A team of four specialists from the Mayo Clinic, Rochester, Minnesota, conducted sessions in Anchorage, Fairbanks, and at Mt. Edgecumbe in Sitka. The visiting consultants were Dr. John W. Kirklin, cardiovascular surgeon; Dr. Robert O. Brandenburg, adult cardiologist; Dr. Owings Kincaid, diagnostic roentgenologist; and Dr. James DuShane, pediatric cardiologist.

This post graduate teaching clinic for physicians and nurses evaluates approximately 150 to 175 patients yearly who have congenital or acquired rheumatic defects that may possibly be amenable to surgery. Dr. Paul G. Isaak, Soldotna, President of the Alaska Heart Association, was general chairman. He was assisted by Doctors Robert Wilkins and Robert Whaley of Anchorage; Donald Tatum, Fairbanks; and Edward D. Spencer and Robert H. Shuler, Sitka.

The Alaska Division of the American Association for the Advancement of Science held its Fifteenth Annual Alaskan Science Conference September 1 through 4 in Fairbanks at the University of Alaska. Current research projects of interest in the Arctic, including the geological and economical features of the recent earthquake were discussed. The Medical Sciences section of the conference was chairmanned by Raymond D. Evans, M.D. of Fairbanks. One of the sessions concerned the relation of the physician, particularly the psychiatrist, to the court of law. The participants included Doctors Karl Bowman, Director of the Alaska State Department of Mental Health and the Alaska Psychiatric Institute; J. Ray Langdon, private psychiatrist, Anchorage; and Joseph Diesher, President of the Alaska State Medical Association, from Seward.

ARCTIC HEALTH RESEARCH CENTER

Dr. H. B. Colyar spoke of Alaska's experience in tuberculosis control at the Pan American Health Organization in Mexico City. He discussed the Arctic Health Research Center's pilot study on the use of isoniazid in the prophylaxis of tuberculosis in a highly susceptible population and in the ambulatory treatment of tuberculosis. It was felt that a similar program could be applied to the scattered small villages of Latin America.

Dr. Colyar has returned as medical officer in charge of the Arctic Health Research Center in Anchorage after a one year leave of absence during which he attended the Industrial College of the Armed Forces at Ft. McNair in Washington, D.C. During his absence, Dr. Edward M. Scott was chief of the center.

Projects of the center during the past year centered around several exanthem outbreaks in isolated villages, such as rubella on St. Paul Island, and on a mass rubeola vaccine program for the Alaskan natives. The latter is a joint project between Arctic Research Center and the Department of Preventive Medicine at the University of Washington School of Medicine. They found that gamma globulin and live vaccine in one dose brings the risk of high fever later after trained personnel have left the village, but found no other serious after effects. Arctic Health Research will co-operate with the United States Public Health Service in a mass rubeola vaccine program for isolated native villages. During the winter of 1964-65 some consideration has been given to using a combination of "killed vaccine" followed in several months by live vaccine with gamma globulin. Participants in this study have included Doctors Jacob A. Brody, Robert McAllister, who has returned to the University of Washington and Dwayne Reid, new epidemioloigst to the Center, who recently served on Guam. In addition, an otitis media study in Anchorage will be undertaken this year.

During the past six months, Dr. Irma Duncan has been running urine amino acid screening surveys on all children referred into the Child Study Clinic with suspected mental retardation.

A three man team from the Radiation Health Division of the Public Health Service in Washington, D.C. has been sent to Alaska to plan for the development in Alaska of a radiation laboratory to analyze meat, milk and other samples for radioactivity, and a facility to measure whole body counts of radioactivity. This activity was stimulated by concern expressed by Senator Bartlett in the U.S. Senate "over the high radioactivity of the caribou herds in the region of Anaktuvak Pass".

ALASKA DIVISION OF MENTAL HEALTH

Harborview Nursing home, for the care of long term mentally retarded patients, which was destroyed during the March 27th earthquake will be reactivated temporarily in the Valdez Community Hospital which is being remodelled to accomodate 40 of the Harborview patients now being housed at Alaska Psychiatric Institute. Plans are now being made for the construction of a new facility for the mentally retarded with a capacity of 150 beds in the new townsite of Valdez.

The Governor's Committee on Alaska's Mental Health and Mental Retardation Planning was appointed early in 1964. At present this is a fifteen member group of whom three are physicians, including Dr. William J. Rader, who has been appointed as chairman; Dr. Helen S. Whaley, both of Anchorage; and Dr. Raymond Evans of Fairbanks. This group held its first orientation meeting at the Alaska Psychiatric Institute in August under the direction of Dr. Karl M. Bowman. Dr. Daniel Blaine, President of the American Psychiatric Association, was present as consultant to the committee and spent the month of August visiting physicians and medical facilities throughout the state. His trip was made possible through a renewal of a $50,000 grant from the National Institue of Health. He has been instrumental in helping formulate comprehensive, long range plans in a number of other states, including California. He is clinical professor of Psychiatry at the University of Pennsylvania.

Dr. Barbara Ure, originally from Minnesota and more recently from New York, has been appointed co-ordinator of the Alaska Planning Committee. She is one of the few Board of Certified Child Psychiatrists in the U.S.A. The first year's work of the committee indicated that problems involving children and adolescents, including juvenile delinquency, were of prime importance because of the relatively large segment of the population in this age group. Other problems discussed included alcoholism; suicide and the high percentage of Alaska Natives who form the hard core of long term permanently institutionalized patients (with many of these individuals demonstrating genetic and organic defects). The complicated financial connotations of a satisfactory mental health program were also discussed.

A rotating residency program, in conjunction with the University of Utah, has been arranged so that one resident rotates through API every month. Three new staff members have been added since May. Dr. John P. Rollins, chief of professional services, formerly of Salt Lake City where he was senior staff psychiatrist for the Veterans Administration and clinical instructor in the Department of Psychiatry at the University of Utah. Dr. Bruce Johnstone, who will serve as physician was formerly at the Dammasch State Hospital in Oregon. New staff psychiatrist is Dr. Marie Massicot-Frain, who joined the staff from State Hospital No. 4 at Farmington, Missouri.

ALASKA DEPARTMENT OF HEALTH

This department has been depleted by a number of resignations. Dr. Edwin O. Wicks will be the new Director of Public Health in New Mexico. Dr. Jack Lesh, former Maternal Child Health Director and Health Officer for Southeastern Alaska, has left to enroll in the School of Public Health in Berkeley, Calif. Dr. A. V. O'Brien, Northern Health Officer, has retired and is returning to Ireland via an all around world trip.

Dr. Thomas McGowan has been appointed the new Director of the Alaska State Division of Health. Dr. Elizabeth Tower is serving as part time Southcentral Regional Health Officer. The remainder of the positions have not yet been filled.

Mr. Lowell Schwartz, was appointed co-ordinator of the Health and Welfare facilities for the Department of Health and Welfare. His chief duties are to implement programs under the Hill-Burton Hospital Act and serve as co-ordinator between Health and Welfare, DPW, and Division of Buildings. He also is responsible for licensing hospitals and nursing homes throughout the state. This position has been vacant since June 1963.

LOCAL

FAIRBANKS: Dr. Alvin Patrick, a 1960 graduate of the University of Oklahoma School of Medicine, joined the Tanana Valley Medical Medical Clinic in July as Fairbanks' second pediatrician. In addition to his pediatric residency in Oklahoma, he had a year of pediatric neurology. Both he and his wife had previously been in Alaska where he served as a Fish and Wildlife surveillance officer. He has four children. Dr. Jean F. Arnold has joined the Tanana Valley Medical and Surgical Clinic in general practice. He is a 1961 graduate of the Boston University School of Medicine and had a rotating internship at the Harrisburg Apolic Clinic Hospital. Dr. William Harland James, formerly of the Tanana Valley Medical and Surgical Clinic, started a pediatric residency at the Akron Children's Hospital in July.

Doctors Nicholas Deely, Henry Storrs and George Clark attended the Ketchikan Medical Association meeting in May, enjoying a ferry ride aboard the Malaspina en route.

VALDEZ: Dr. Clarence Davis is presently at the University of Tennessee School of Medicine taking neurosurgery residency.

PALMER: Dr. Boyd Skille, has entered an opthalmology residency in Buffalo, New York.

Dr. Marshall Simpson, formerly of Palmer, more recently of Eagle River, has left his practice to take a psychiatric residency in Iowa under the auspices of the National Institute of Health Fellowship. Eagle River is currently without the services of a physician although Dr. Robert Billings of Anchorage will hold office hours there three times weekly.

NOME: Robert E. Fenstermacher, M.D., Administrator of the Maynard-McDougall Memorial Hospital in Nome is the President of the Alaska Hospital Association which held its annual convention at the University of Alaska the first week in September. Dr. John Shadler, formerly of Nome, entered private surgical practice in Kentucky.

GLENNALLEN: Dr. Chester Schneider is on his sabbatical leave with Dr. Pinneo being in sole charge of Faith Hospital. Dr. Pinneo attended the Ketchikan Medical meetings.

KODIAK: Dr. Bruce Keers is planning to start a radiology residency in Albany, New York, in 1965.

KENAI-SOLDOTNA: Dr. Alan Barr has left this community to enter practice with Doctors Phillips and Bartko in Anchorage. Doctors Gaede and Isaak of Soldotna continue to service Kenai and to fly to other communities such as Homer and Cordova to serve as temporary locum tenens so that Dr. Fenger of Homer and the Doctors Chapman of Cordova can attend medical meetings. Dr. Isaac attended the medical meetings in Ketchikan in May and both Doctors Isaac and Gaede presented patients at the Cardiac Clinic in Anchorage in September.

BETHEL: Dr. Harriet Jackson Schirmer continues in private practice in this area using her home as an office, delivery room and nursery. She, her husband and infant son flew outside in a private airplane to visit the New York Fair this summer following a brief visit to the Medical Association meeting in Ketchikan.

JUNEAU: Dr. George Cummings Miller has returned to his native Scotland after practicing briefly with the Juneau clinic. Dr. Joseph Rude was the only Juneau physician in attendance at the Ketchikan medical meeting. His associate, Dr. Reiderer had intended to attend but was prevented from doing so by a "blessed event" in his own family.

KETCHIKAN: Dr. Arthur Wilson Jr. has left this community to practice internal medicine in Oregon. Dr. Irving O. Winton also left private practice in Ketchikan this past spring.

ANCHORAGE: Dr. Charles P. Bailey, noted cardiologist from St. Barnabas Hospital of New York City, was the guest speaker at the Presbyterian Medical Center staff meeting in August. In September, Dr. Don Val Langston became a diplomate of the American Board of Pediatrics. Dr. Langston, as Providence Hospital Chief of Staff, spoke to the Washington State Medical Association meeting on September 13 about "Medical Disaster Programs" discussing medical and hospital problems during the Alaska earthquake.

He emphasized need for an auxiliary water supply and ham radio equipment to maintain some type of communication. He also published an article in the July 27 JAMA on "A Hospital in a Disaster Area". Doctors Milo Fritz and Nancy Sydnam flew in private planes to St. Mary's Mission and the surrounding Kuskokwim area during September to hold pre-school physical and ENT clinics for the children of that and neighboring communities. Dr. Winthrop Fish attended an advanced post-graduate course in internal medicine at the Harvard Medical School in June of 1964. Dr. Donald Kettelkamp left practice in Anchorage to become an Assistant Professor of Orthopedics in Albany, New York. Dr. A. Claire Renn spent part of September in Hawaii where she caught a 185 lb. Marlin. Dr. Jack Sedwick escorted Stein Ericksen, noted former Olympic skier and ski instructor to some of the fishing and hunting areas in Alaska. Dr. Richard Chao visited the New York World's Fair in June of 1964. Other World Fair visitors included Dr. Harvey Zartman. Dr. Rodman Wilson escorted his family home from Morocco, where they had spent a year, visiting Spain, Portugal, France and England en route.

New Anchorage physicians include Doctors Ollie and Wally Dunn, formerly of the ANHS Hospital and more recently from Chicago. Dr. Wallace Dunn has completed an ear, nose and throat residency and his wife Ollie, a dermatology residency. Dr. Michael Hein, a University of California graduate who has recently completed a surgical residency at the San Francisco institution with emphasis on vascular surgery, is also entering private practice. Dr. Sam Depelatis, a 1956 graduate of the University of Colorado, who completed a surgical residency at the Virginia Mason Clinic has joined the Doctors Clinic. Dr. L. David Ekvall, a medical graduate of the College of Medical Evangelists, Loma Linda, California, in 1955, with OB-GYN training at Tulane University has joined the Anchorage Medical and Surgical Clinic. He was stationed in Kodiak with the U.S. Navy from 1962-1964 and is a Diplomate of the American Board of Obstetrics and Gynecology.

Doctors Robert and Shirley Fraser have also entered Anchorage. Dr. Robert Fraser, formerly of the USPHS, Kotzebue, has had considerable post-graduate training in chest disease both in Philadelphia and England. He has joined the Health Department as Tuberculosis Control Officer. His wife, Shirley, who has had additional training as a neurologist at the Great Orman Street in England is a member of the USPHS ANS Hospital medical staff.

SKAGWAY: Dr. David Samann, flew his own, personally modified airplane to the Ketchikan medical meeting with his wife and toured southeastern Alaska on his return.

PETERSBURG: Dr. Duane Coon commuted daily to the Ketchikan medical meeting in his own float plane and delivered babies enroute at Wrangell, which he also covers medically.

SAND POINT: Dr. Carl Sandburg, his wife, two children and a baby-sitter travelled via ferry to Ketchikan in May and then returned by way of the White Pass and Yukon Railway, spending several days visiting Doctors Pinneo and Schneider in Glennallen.

WANTED: M.D. to share practice in Kodiak, Alaska's oldest, most promising and prettiest community; population 3500 and growing. Must be general practitioner or general surgeon willing to do some general practice temporarily. Equipped clinic facilities available for rent. Separate billing and separate practice as desired. Community Hospital, nineteen beds, with complete x-ray and laboratory services. Forty-five to fifty-hour week. Home for lunch. A challenging country and a challenging practice. Contact R. Holmes Johnson, M.D., Box 1727, Ph. 486-2171.

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Volume 6, Number 4 December, 1964

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Alaska Medicine

Volume VI, No. 4 **December, 1964**

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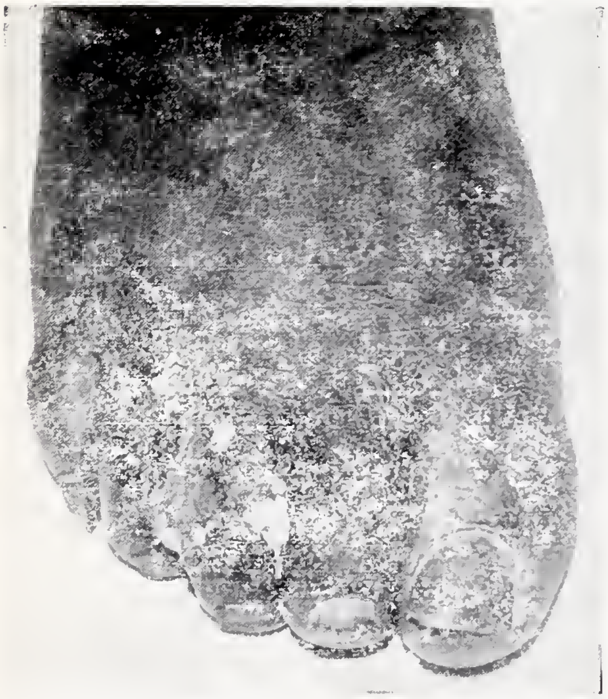

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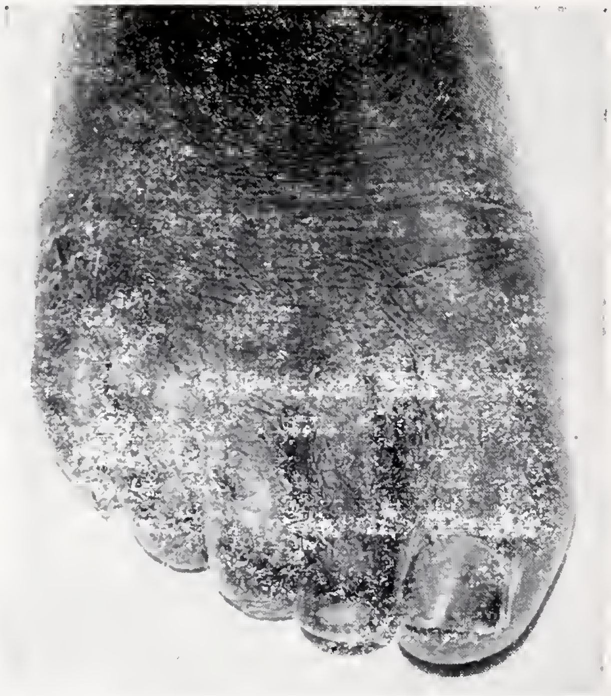

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ATHEROSCLEROTIC CORONARY HEART DISEASE

The Major Challenge to Contemporary Public Health and Preventive Medicine*—Part II

JEREMIAH STAMLER, M.D.

Director Heart Disease Control Program and Division of Adult Health and Aging, Chicago Board of Health;
Executive Director Chicago Health Research Foundation; Assistant Professor, Department of Medicine,
Northwestern University Medical School, Chicago, Illinois

The possibility of achieving primary prevention of premature clinical coronary heart disease: With regard to this key question, one of the remarkable achievements of recent research is the identification of factors influencing risk of developing this disease, and based on this, the development of the ability to find susceptible individuals before they become sick, and to intervene in an effort to decrease their coronary proneness.

It is an axiom of preventive medicine that in order to develop truly effective programs of primary prevention, it is essential to focus and concentrate the effort against the susceptibles. In polio, for example, children and pregnant women are susceptible. Therefore—while an effort is made to immunize the entire population—particular attention is devoted to inoculating the susceptibles.

Therefore, one of the major advances in the field of coronary disease in recent years is the recognition that people vary markedly in their susceptibility to this disease. The data on ability to detect susceptibles demonstrate that the figure on the average risk of the average American male —one chance in five of developing a heart attack in middle age—is, like many averages, an abstraction of only limited meaning. It is an average of very different risks, for there are in the American population those who have findings indicating marked susceptibility, as high as one chance in two or two chances in three or worse of developing coronary disease before age 65. At the other end of the distribution, there are more fortunate individuals with a risk of only one in 20, one in 30 or one in 40.

A corollary and byproduct of this achievement is assessing susceptibility and the ability to identify coronary prone individuals before they develop overt clinical disease. The methods for making this assessment of risk are quite simple. They entail making a set of standard medical measurements.

The first point worth re-emphasizing with respect to coronary-proneness is the remarkably greater susceptibility of men compared to women, particularly prior to age 45, that is prior to the

TABLE 7

Diastolic Blood Pressure (1958) and Disease Incidence — 1329 Men, Age 40-59, on January 1, 1958
Chicago Utility Company Study

Event	No. and Rate of Events									
	± 80 mm Hg. 479 Men		80-90 mm Hg. 565 Men		90-94 mm Hg. 151 Men		95 ± mm Hg. 134 Men		All 1329 Men	
All Deaths 1/1/58 - 10/31/63	16	33.4	22	38.9	8	53.0	17	126.9	63	47.4
CHD Deaths 1/1/58 - 10/31/63	3	6.3	10	17.7	3	19.9	6	44.8	22	16.6
Stroke Deaths 1/1/58 - 10/31/63	2	4.2	4	7.1	1	6.6	3	22.4	10	7.5
CHD Deaths 1958 - 62	2	4.2	5	8.8	0	....	3	22.4	10	7.5
CHD Incidence 1958 - 62	5	10.4	23	40.7	7	46.4	1	82.1	46	34.6
MI Incidence 1958 - 62	2	4.2	12	21.2	6	39.7	4	29.9	24	18.1

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*Presented at the 19th Annual Convention of the Alaska State Medical Association, Ketchikan, May 28, 1964.

onset of menopause in women. Middle-aged women, particularly white women, are in general highly resistant to this disease (Table 6). This female resistance to heart attacks is the single main factor accounting for the six year greater life expectancy of women than men in the United States today. The fact that early widowhood is a major social problem, is attributable first and foremost to the impact of coronary disease on men. In the Framingham study, there were no heart attacks in women under age 40, whereas there were 21 per thousand in men (Fig. 5). The contrast was similar for the age group 40 to 49. This sex differential began to lessen only in the age group 50 to 59, and gradually decreased thereafter. First of all, therefore, in the evaluation of risk, it is essential to recognize that men are generally more susceptible than women. This fact, however, should not be exaggerated, since women after the menopause develop an increasing coronary proneness, as is evident from the above-cited statistics (Table 6 and Fig. 5). It is not possible in this report to digress and describe the research done on the role of internal secretions—particularly the estrogenic hormones of the ovary—in protecting women prior to the menopause (for references see the Bibliography).

The relationships between two key variables—blood pressure and serum cholesterol level—and coronary proneness are illustrated in Table 7 and Figures 6-8. Men with elevated blood pressure had a manifold greater risk of developing coronary disease than men with normal blood pressure. Men with high serum cholesterol levels developed three to five times as many heart attacks as men with lower serum cholesterol levels. Those normal with respect to both factors had only 10 heart attacks per thousand in 40 months—a risk of about one in 20 of developing coronary disease

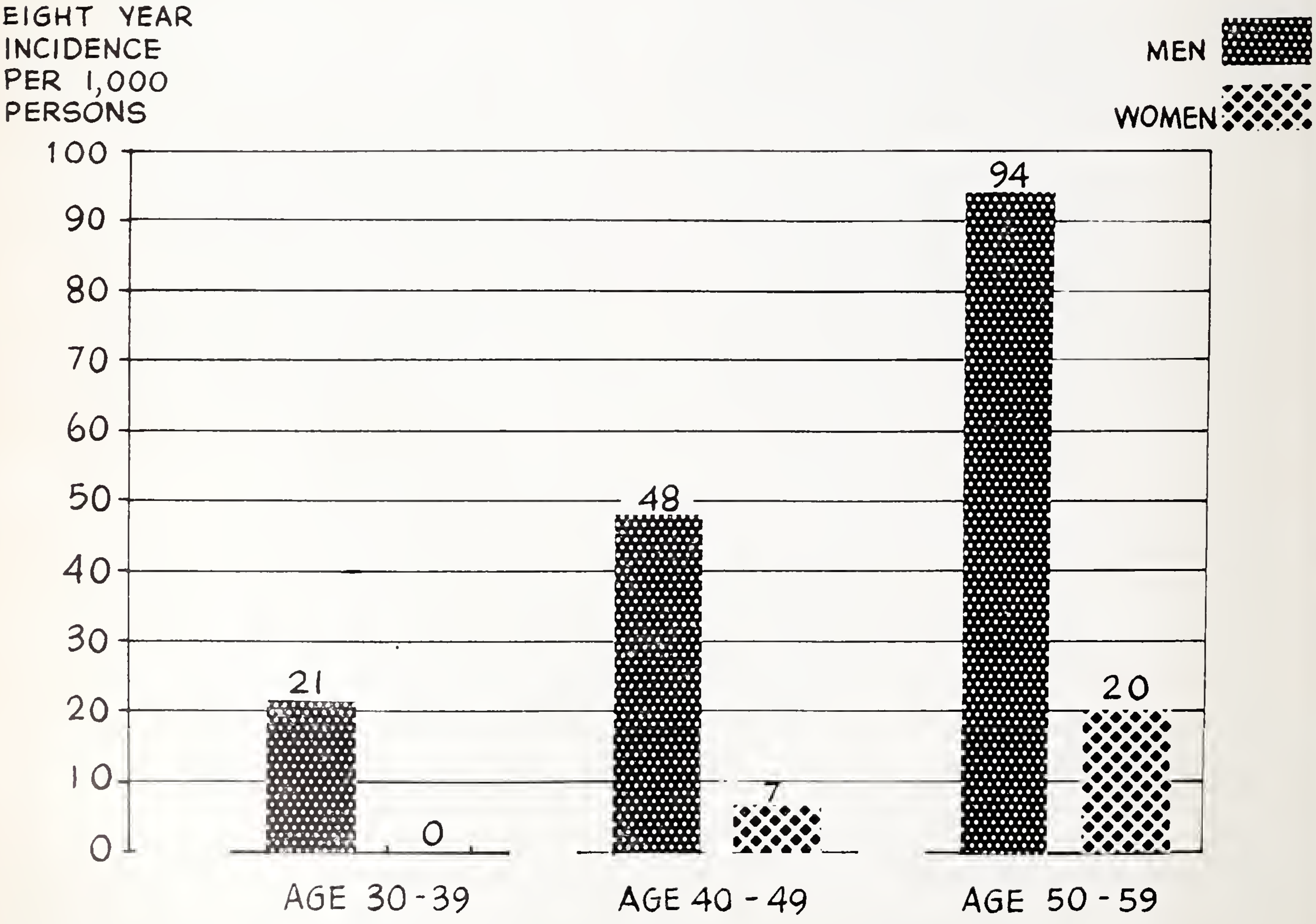


FIGURE 5

Eight-year incidence of heart attacks in Framingham Study, men and women age 30-59 at entry.

before age 65. Those with both these abnormalities had seven-to nine-fold higher incidence rates, amounting to a risk of about one chance in three or worse of developing a heart attack in middle age. These are some of the high risk men in the U.S. population.

Another important factor influencing risk is smoking, particularly cigarette smoking (Fig. 9). Note that no coronary events occurred during the first 40 month of follow-up, from 1958 to 1962, in the 151 men who never smoked. Among the 169 men who had quit by 1958, while they were still free of disease, only 2 coronary episodes ensued, giving a low rate of 12/1000 men in 40 months, or less than 4/1000/year, i.e. about one third the average rate. Smokers fared far worse, exhibiting rates 3 to 5 times higher than those who had quit smoking.

Many other studies in Great Britain and the United States have reported similar findings; data from one of these are presented in Figure 10. Note the six-fold difference in total death rates between non-cigarette smokers and cigarette smokers. Note also that these data from the Framingham and Albany studies, involving several thousand men followed for six and eight years respectively (the death rates are given as deaths per thousand men per year), demonstrate a more than six-fold difference in fatality rate from myocardial infarcation in cigarette smokers vs. non-cigarette smokers, and a difference in rate of all heart attacks (fatal and non-fatal) that is more than three-fold. These statistics deserve to be carefully pondered.

Few people appreciate that cigarette smoking is a twentieth century habit. As a mass phenome-

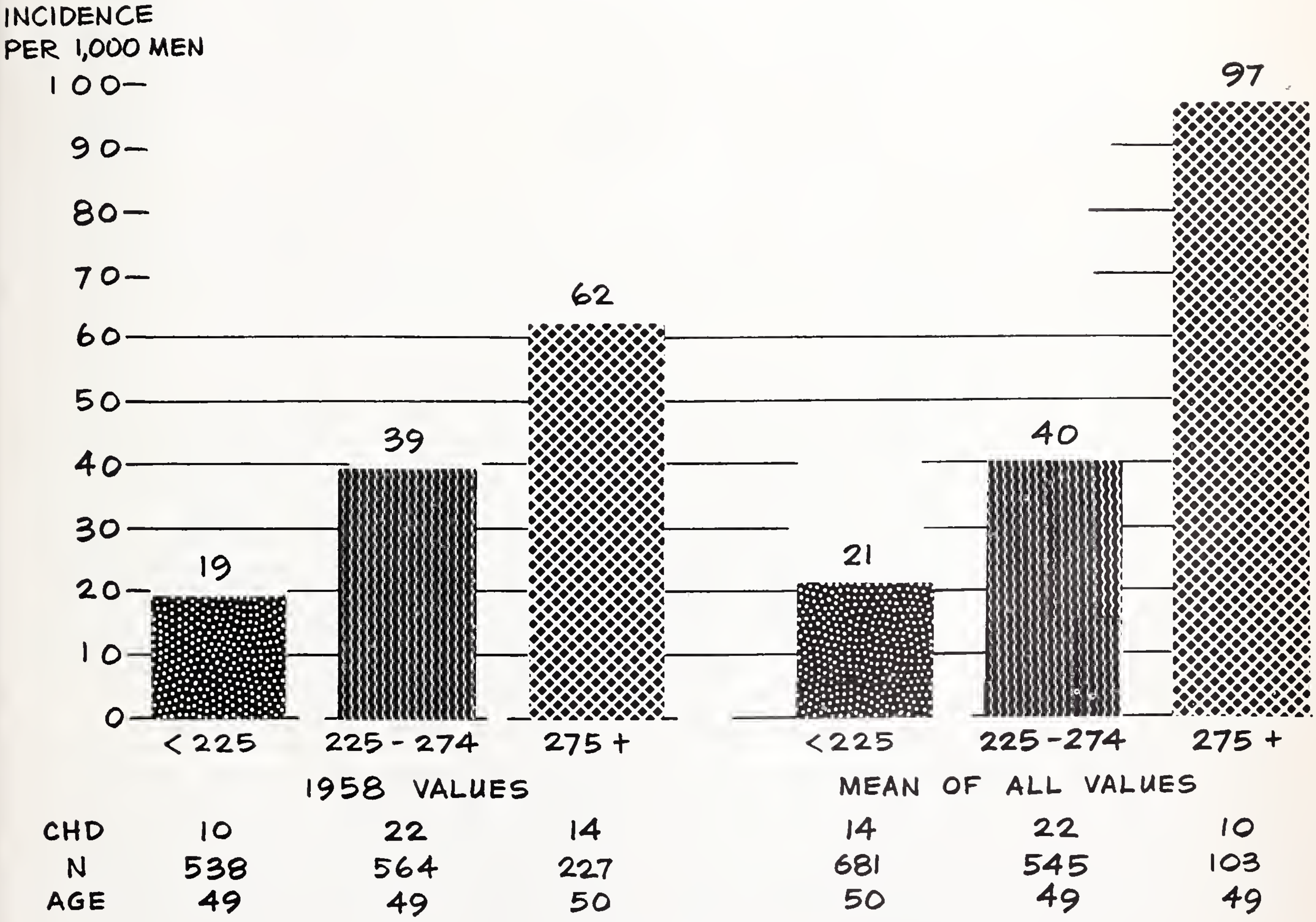


FIGURE 6

Relationship between serum cholesterol level and incidence of Coronary Heart Disease in the Peoples Gas Light and Coke Company Study, 1958-1962. The 1958 values represent a single determination on each man. The mean of all values represents a mean of all available data for each man, assessed at intervals from 1958 to 1962.

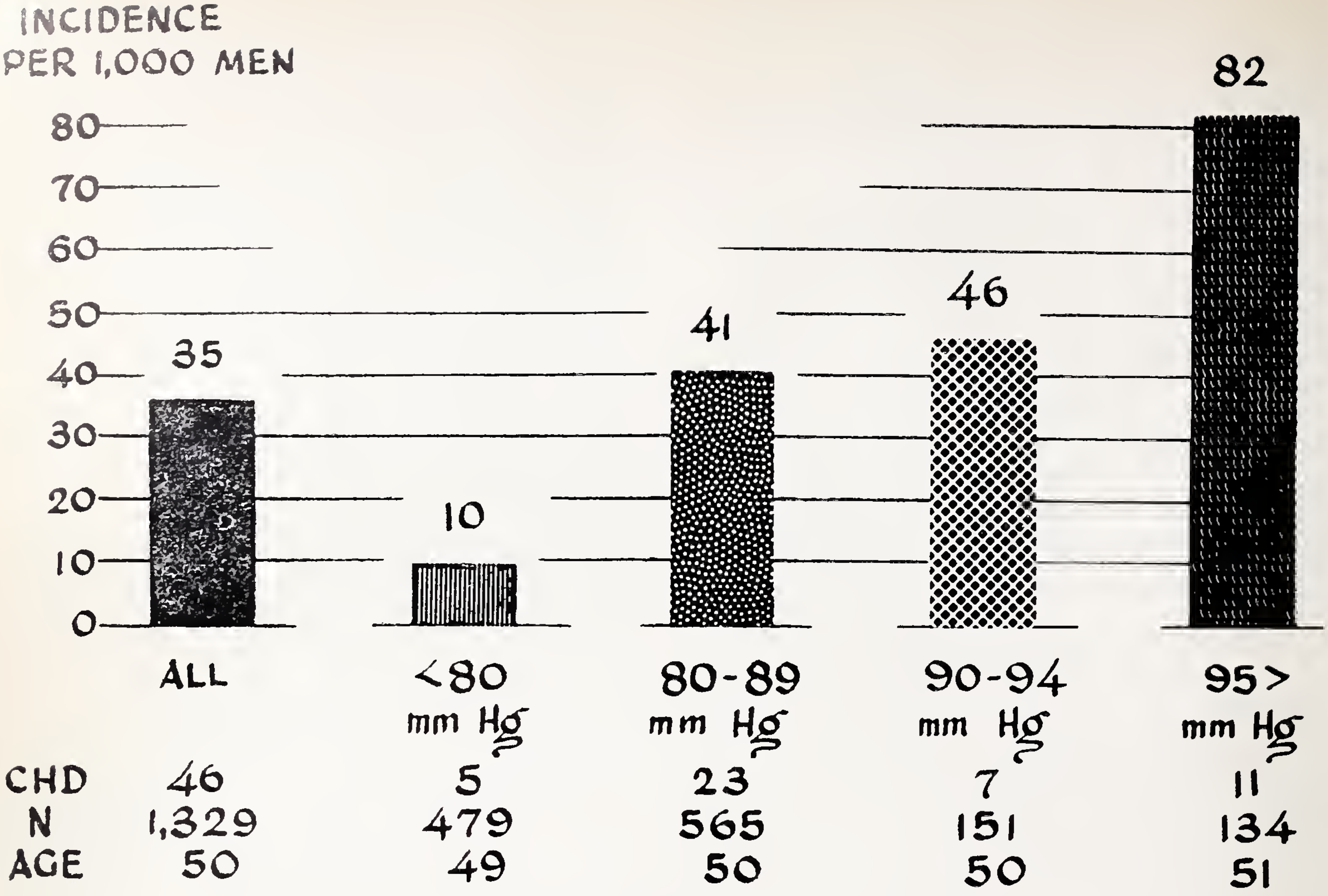


FIGURE 7

Relationship between diastolic blood pressure in 1958 and incidence of Coronary Heart Disease, 1958-62, in the peoples Gas Light and Coke Company men age 40-59 in 1958.

non, it in no sense dates back to Sir Walter Raleigh. Its first prerequisite was the invention of machines for the large scale manufacture of cigarettes, a development that occurred toward the end of the nineteenth century. The second prerequisite was the adoption of the habit en mass, an event occurring during and after World War I (Fig. 11).

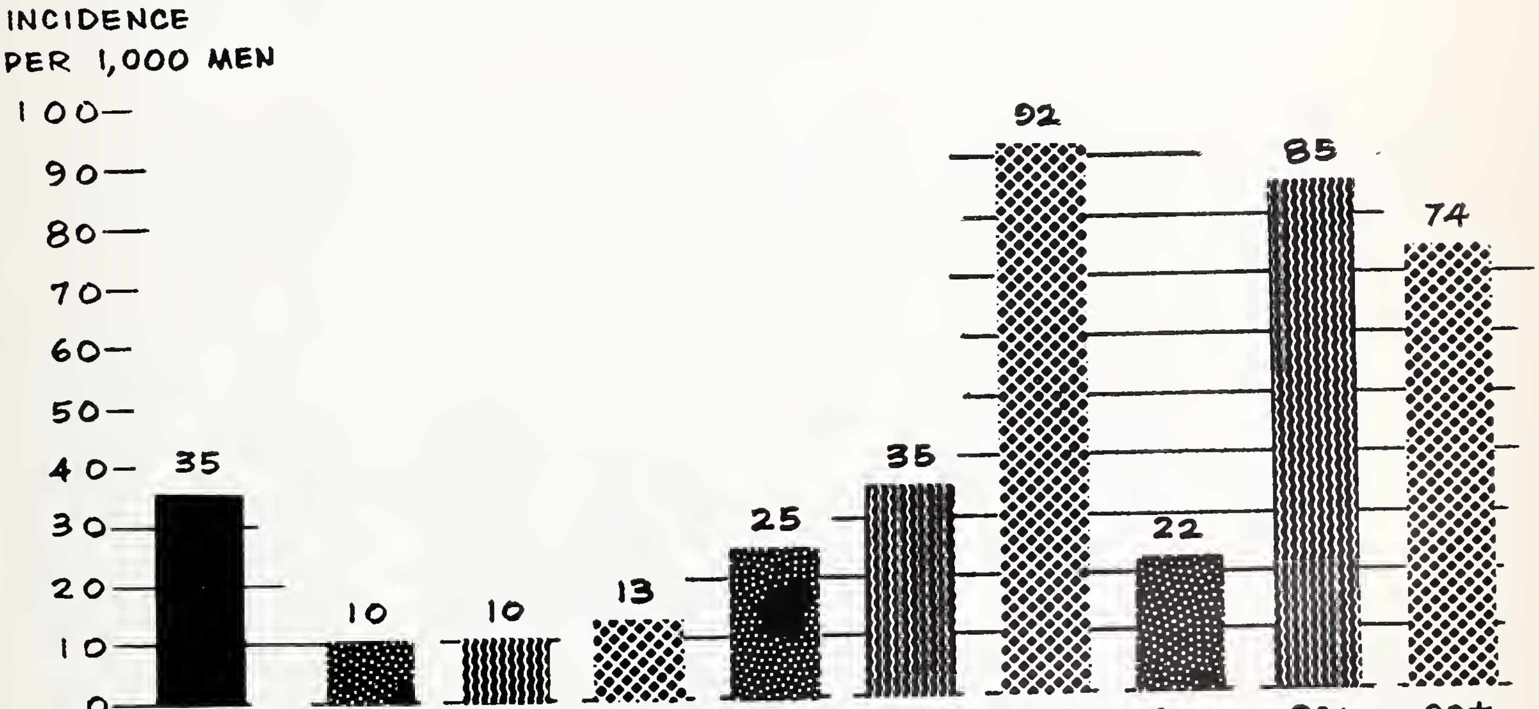
Considerable research evidence is available indicating that this development is one among three parallel alterations in the American way of life—changes in habit patterns which together have contributed significantly to the increased incidence of premature atherosclerotic coronary heart disease in the U.S. population. The other two are the inexorably developing habits of physical inactivity and excessive ingestion of diets high in saturated fats and cholesterol.

The prospective epidemiologic data further reveal that when smoking is combined with hypercholesterolemia, or with overweight, the risks rise proportionately, and the differences in coronary proneness between persons not stigmatized by these abnormalities and those demonstrating these risk factors are several fold (Figs. 12 and 13). When the analysis is extended to include simultaneously status with respect to four risk factors—hypercholesterolemia, hypertension, smoking and overweight—then the range of risks is very great indeed (Table 8).

Up to this point, consideration has been given to findings that are not direct measurements of the status of the heart or coronary arteries per se. Rather, they are measurements of physiological variables (blood pressure, weight, serum cholesterol) known to influence the development of atherosclerosis. These variables are therefore properly designated as coronary risk factors. Other coronary risk factors include diabetes, thyroid disease, kidney abnormalities, lack of exercise, and a history of blood vessel disease (atherosclerosis, hypertension) occurring prematurely (before age 60) in members of the family.

Medicine has also increased its knowledge in another area of vital importance for predicting risk of developing frank clinical coronary disease. It has definitely shown that certain abnormalities revealed by the electrocardiogram—abnormalities frequently found during routine examination of presumably healthy people—also portend an increased likelihood of developing heart attacks during the ensuing years. The electrocardiogram is therefore an invaluable means of assessment, of detecting persons with coronary disease before they have developed symptoms and become direct information concerning the status of the heart. Several abnormalities demonstrable by the electrcardiogram are indicative of damage to the heart probably due to atherosclerosis of the coronary arteries supplying blood to the heart muscle (Fig. 14). When these abnormalities are encountered in apparently healthy people (as is often the case), they are therefore warning signals that frank heart attack is more likely to occur.

In the Framingham study, an assessment was made of the relationship of three measurements—the electrocardiogram, blood pressure and serum cholesterol—and risk of developing frank clinical coronary disease. Those men normal with respect to all three of these experienced very few heart attacks in the ensuing years. Those with one abnormality experienced a twelve-times higher attack rate; those with two abnormalities, a twenty-times higher rate; those with all three abnormalities, a thirty-three-times higher rate! These statistics illustrate with a vengeance the value of these measurements in detecting coronary prone persons—and the challenge to preventive medicine such persons present!



	ALL	<80 <225	<80 225-274	<80 275+	80-89 <225	80-89 225-274	80-89 275+	90+ <225	90+ 225-274	90+ 275+
CHD	46	2	2	1	6	8	9	2	12	4
N	1,329	209	195	75	239	228	98	90	141	54
AGE	49	48	49	50	49	50	50	51	50	51
WEIGHT RATIO	1.16	1.10	1.12	1.13	1.17	1.19	1.17	1.18	1.22	1.22
PERCENT SMOKERS	60%	67%	63%	72%	63%	53%	66%	50%	52%	59%

FIGURE 8

Relationship between diastolic blood pressure, serum cholesterol and incidence of Coronary Heart Disease, 1958-1962, Peoples Gas Light and Coke Company men age 40-59 in 1958.

The next relevant question is: How frequently are coronary-prone persons encountered in the population? The studies of middle-aged men employed by the Peoples Gas Light and Coke Company have yielded highly significant data on this matter—again, data typifying the general situation prevailing throughout this country today. Over 500 men per thousand were found to be overweight, 284 per thousand markedly overweight; 283 per thousand had a high serum cholesterol level; 103 per thousand had frank high blood pressure; more than 400 per thousand were heavy smokers; 175 per thousand had a positive family history of premature blood vessel disease (Fig. 15).

Men with two or three risk factors were frequently encountered (Table 8). This is—let it be emphasized—a typical contemporary American situation. Let not the Gas Company be stigmatized—its labor force is "par for the course." At the other end of the risk spectrum, men free of multiple abnormalities are all too rare. Among the middle-aged employees at the Gas Company, only 136 of 1,465 men (9.3%) had normal serum cholesterol, weight and blood pressure (all three combined); further exclusion of diabetics, heavy smokers and men with a positive family history left only 48 men (3.3%) normal with respect to all six risk factors!

The next logical step in the argument is a relatively simple one: something can be done about most of these abnormalities. True, for the sake of preventing heart attacks it is not reasonable to feminize men with estrogenic hormones. Nor is it possible, so far, to influence genetic background and at that level counteract the influence of family history. However, even with respect to family history, there is no reason for fatalistic hopelessness. For it is now known that to a large degree the familial tendency to premature coronary disease results from familial tendencies to high serum cholesterol, to obesity, to high blood pressure, to diabetes—familial tendencies that seem to be in many cases partly genetic and partly environmental in origin. And it is quite

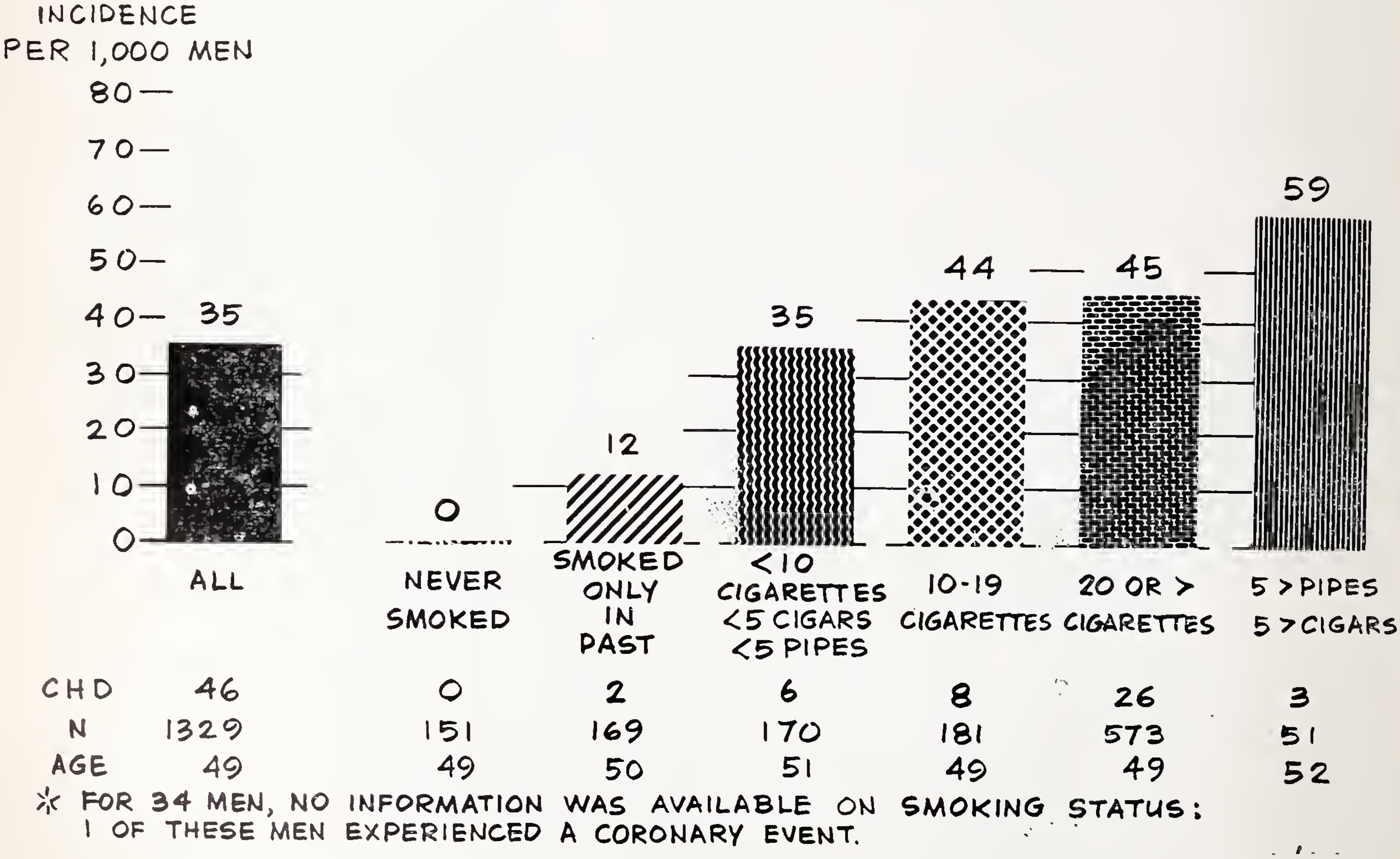


FIGURE 9

Relationship between smoking and incidence of Coronary Heart Disease, 1958-1962, Peoples Gas Light and Coke Company men age 40-59 in 1958.

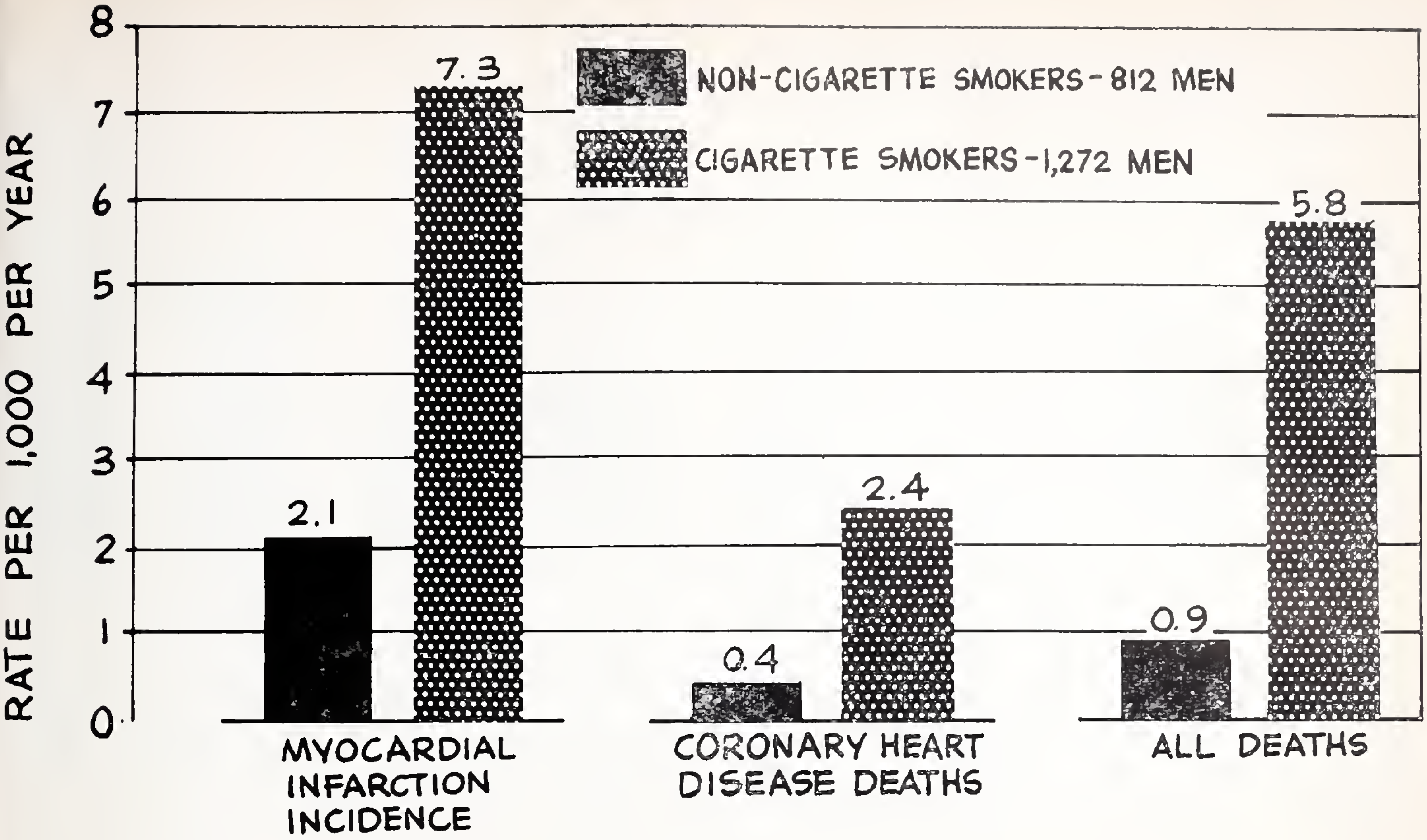


Figure 10

Relationship between smoking and incidence of Myocardial Infarction, Coronary Heart Disease mortality and mortality from All Causes, men age 40-49, Framingham and Albany Studies. Albany follow-up period—6 years, Framingham—8 years. Rates of Myocardial Infarction incidence and Coronary Heart Disease death are adjusted to assess contribution of cigarette smoking independent of cholesterol, weight and blood pressure.

possible for contemporary medicine to treat every one of these abnormalities, if they are recognized early, that is, before frank coronary disease has occurred. It is therefore possible to intervene and attempt to head off the effect of a poor family background.

In any case, the coronary risk factors are often present without a positive family history, and are highly amenable to effective medical therapy. High blood pressure can today be successfully treated by diet and safe new drugs, particularly when it is detected early, before the hypertension is severe, and serious organ damage has developed. Obesity can also be treated by reliable, professional methods, although its longterm control is a tough problem. Heavy smoking, particularly cigarette smoking, can also be eliminated, although it too is a tough problem. It is now known that elevated serum cholesterol can be lowered in most cases by dietary means entirely compatible with continued enjoyment of the pleasure of good eating. Diabetes is also capable

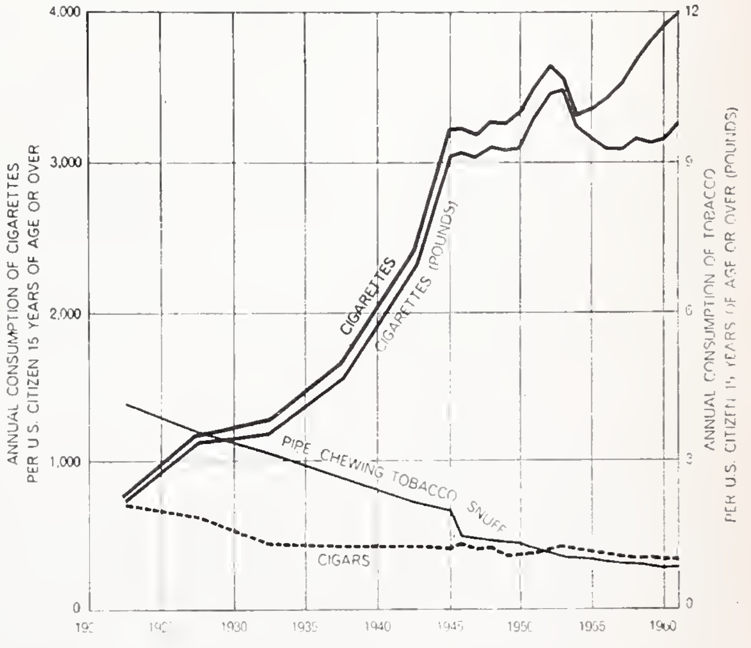
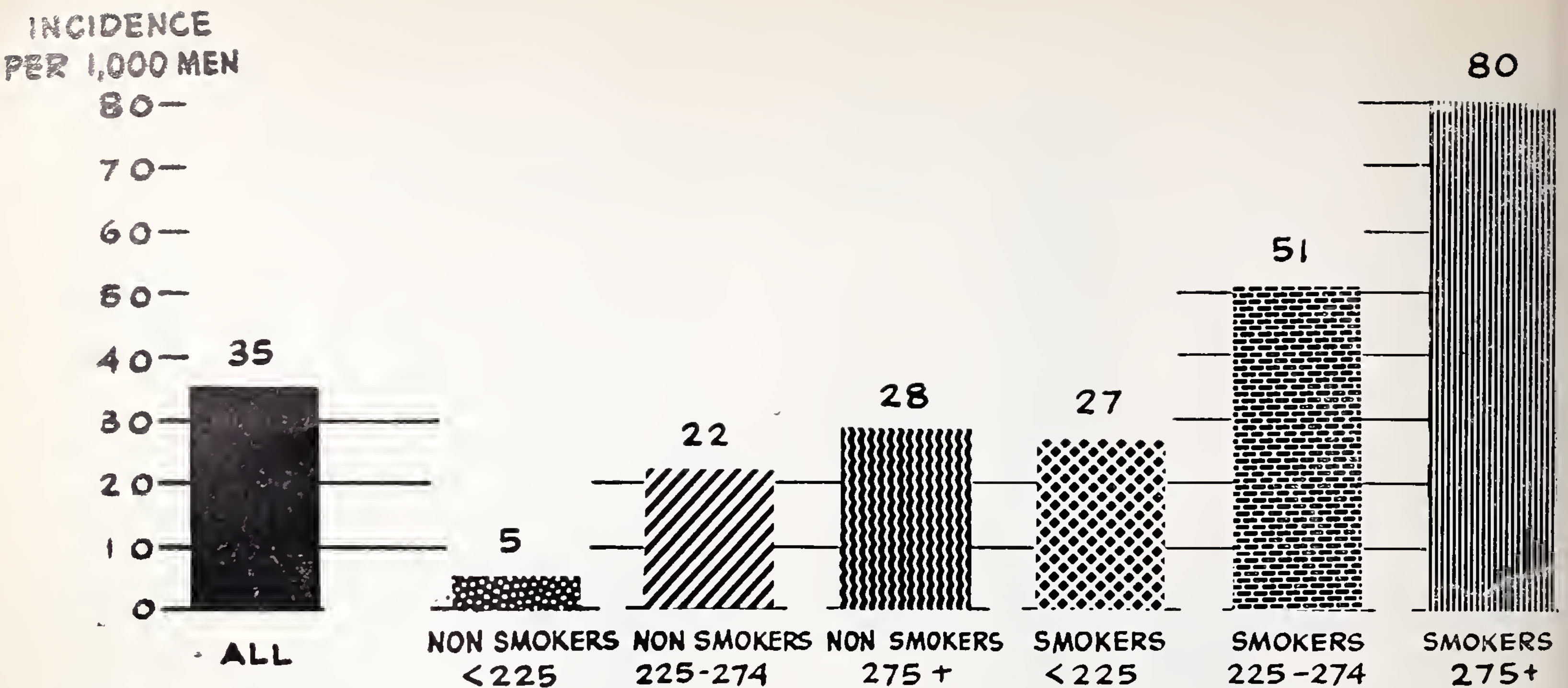


Figure 11

Changes in tobacco use, 1920-60.



	ALL	NON SMOKERS <225	NON SMOKERS 225-274	NON SMOKERS 275 +	SMOKERS <225	SMOKERS 225-274	SMOKERS 275+
CHD	46*	1	5	2	9	16	12
N	1329*	187	233	71	336	317	151
AGE	49	49	50	51	50	49	50
SYSTOLIC PRESSURE	134	133	136	139	131	133	135
WEIGHT RATIO	1.16	1.19	1.21	1.18	1.12	1.15	1.17

* FOR 34 MEN, NO INFORMATION ON SMOKING STATUS WAS AVAILABLE; 1 OF THESE MEN HAD A CORONARY EPISODE.

FIGURE 12

Relationship between smoking, serum cholesterol level in 1958 and incidence of Coronary Heart Disease, 1958-1962, Peoples Gas Light and Coke Company men age 40-59 in 1958.

TABLE 8

Relationship between 4 Coronary Risk Factors (Serum Cholesterol, Blood Pressure, Weight, Smoking) and Coronary Heart Disease — Chicago Utility Co. Study, 1958-62

Risk Factor Status	No. of Men	Coronary Disease Incidence	
None Positive	94	1*	10.6†
Smoking Only	260	8	30.8
Overweight Only	161	0	......
Any One Only of Three (Overweight, Hypertension, Hypercholesterolemia)	227	2	8.8
Any One Factor Only of All Four	487	10	20.5
Smoking + Obesity — 2 Only	169	4	23.7
Smoking + Hypercholesterolemia — 2 Only	125	4	32.0
Any 2 Only of 3 (Overweight, Hypertension, Hypercholesterolemia)	159	4	25.2
Any 2 Only of All Four	484	12	24.8
Smoking + Overweight + Hypercholesterolemia	90	5	55.6
Smoking + Overweight + Hypertension	55	6	109.1
Overweight + Hypertension + Hypercholesterolemia	45	2	44.4
Any Three Only	222	17	76.6
All Four Positive	42	6	142.9
Any Three or All Four	264	23	87.1
ALL	1329	46	34.6

*No. of Men †Incidence rate per 1,000 men. 1/64

Cutting points: Overweight—observed weight/desirable weight, 1.15 >; hypercholesterolemia—1958 value 250 mg. per 100 ml. >; hypertension—lowest diastolic in 1958 90 >; smoking—10 or > cigarettes per day.

of being controlled, as are other coronary risk factors.

It is a simple logical conclusion that if these abnormalities can make for increased likelihood of heart attacks, and these abnormalities can be detected before attacks occur, and corrected and controlled, then the possibility arises of preventing heart attacks. How valid is this logical possibility? Here it is necessary at present to give an interim answer. Several sets of data are available which are very encouraging in this regard. For example, data available indicating that heavy cigarette smokers who quit before they become ill will in due course experience a decline in coronary proneness down toward the risk of non-cigarette smokers (Figs. 9, 16). This is indeed a very encouraging fact.

Life insurance data also available indicating that obese men who reduce and stay reduced (in order to be re-rated at standard rates by their insurance companies) also have a subsequent mortality experience like that of non-overweight men.

Data collected during the last five or ten years of the use of the new drugs for the treatment of hypertension indicate that modern effective control of high blood pressure leads to reduced incidence of heart attacks, heart failure, strokes and kidney failure—the complications that produce illness and premature death in hypertensives. As a result of the control of high blood pressure by diet and the new drugs, hypertensives are now living longer.

While it is a debatable question, there is evidence indicating that well controlled diabetics suffer significantly less from the major complication of diabetes (heart attacks, strokes and other vascular complications) than do poorly controlled diabetics. Finally there is considerable evidence collected in central Europe after World War I and in the occupied countries during World War II indicating that the changes in diet, exercise and smoking under wartime conditions were associated with significant declines in mortality rates from heart attack. All these intriguing

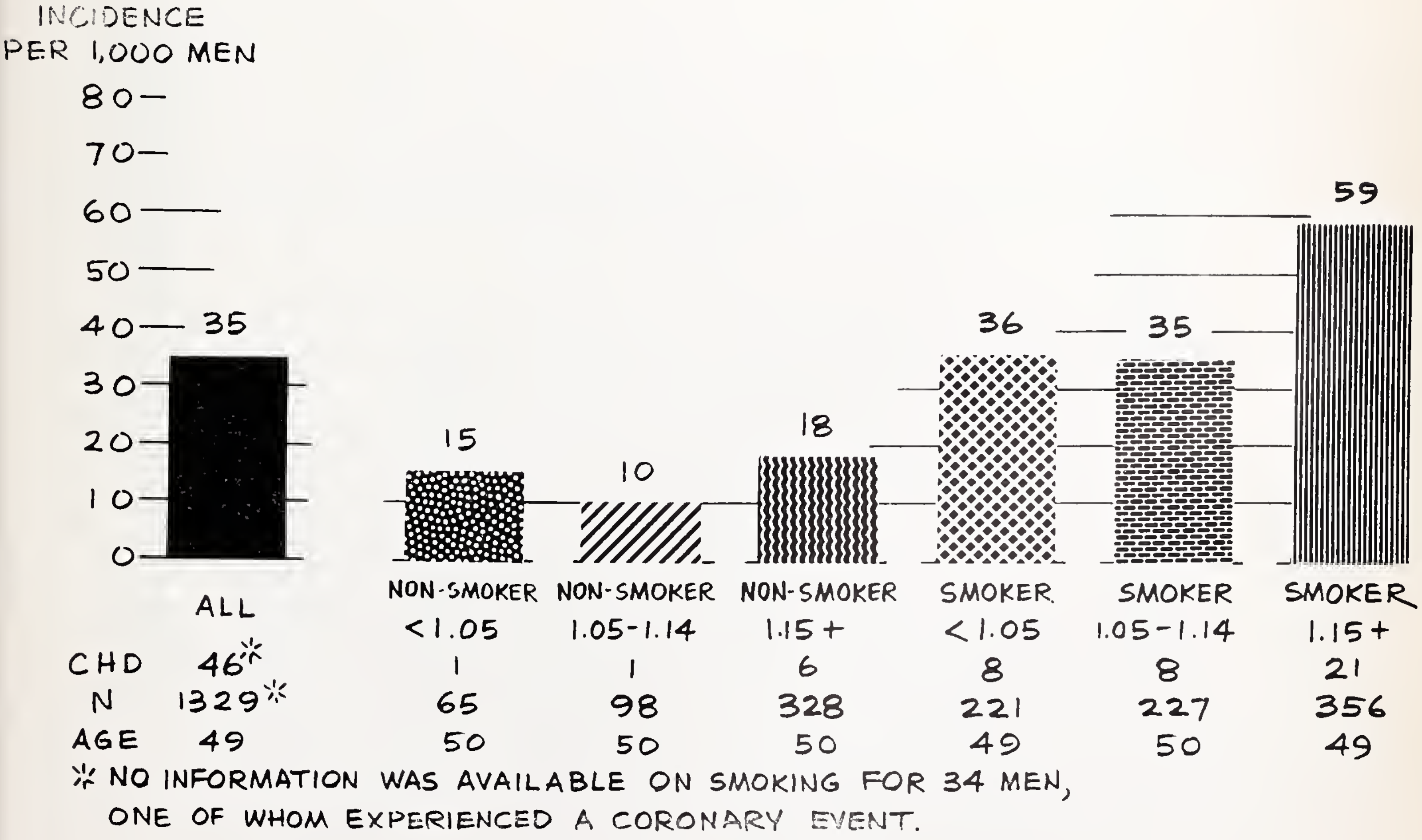


FIGURE 13

Relationship between weight, smoking and incidence of Coronary Heart Disease, 1958-1962, Peoples Gas Light and Coke Company men age 40-59 in 1958.

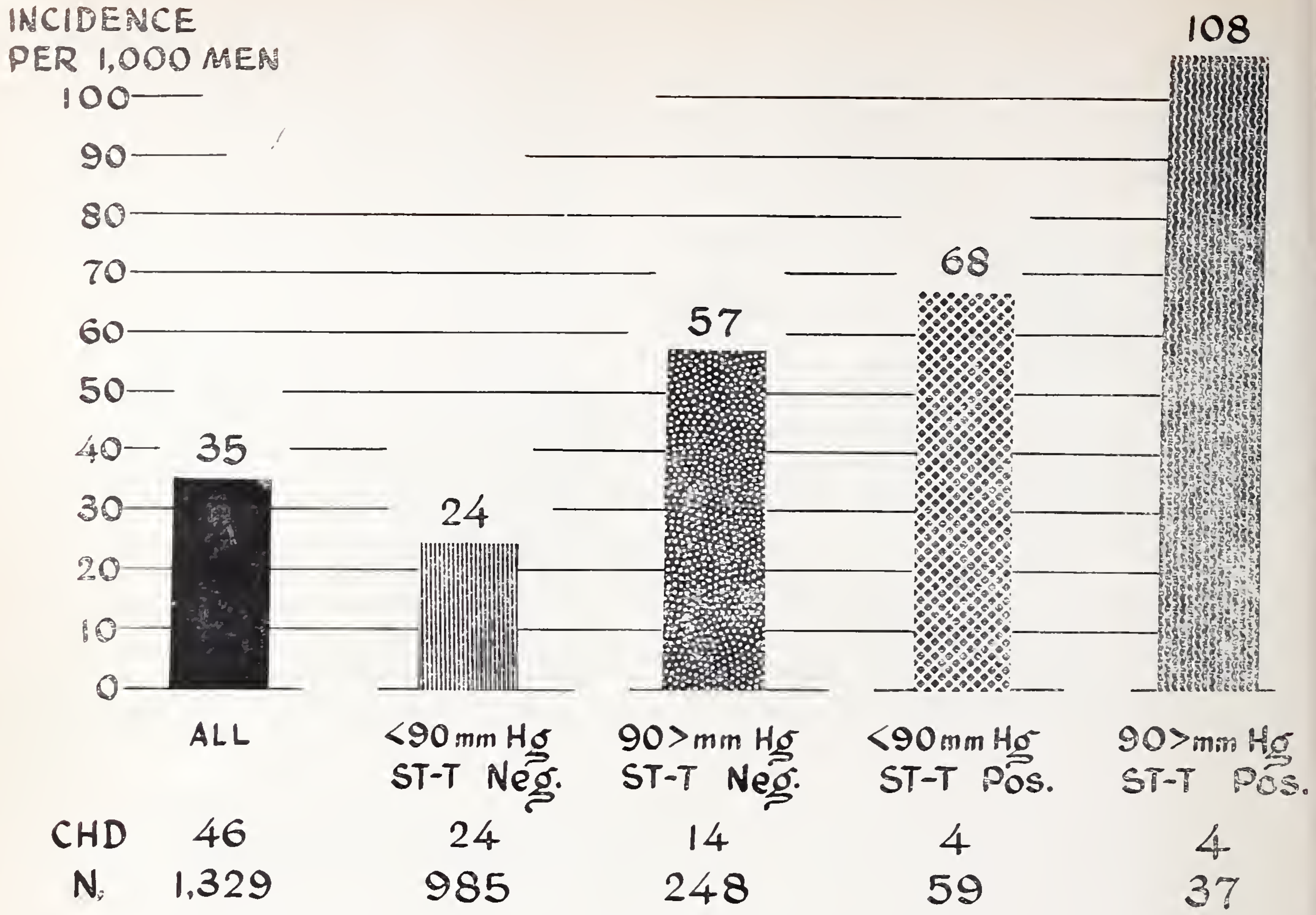


FIGURE 14

Relationship between diastolic blood pressure, non-specific ST-T abnormalities and incidence of Coronary Heart Disease, 1958-1962, Peoples Gas Light and Coke Company men age 40-59 in 1958.

pieces of information support the logical conclusion that treatment of coronary risk factors may be effective in preventing the disease.

When the American Heart Association a few years ago arrived at the conclusion that the available data warranted a statement on diet, heart attacks and strokes, they issued such a statement to the profession and the public. This statement was very carefully formulated so as to be neither too negative nor too positive, based on the data available. This statement emphasized the possibility of prevention—not the certainty at this juncture, because the data available today are not yet comprehensive enough to warrant our speaking about the certainty of prevention—"merely" the possibility. The more recent statement of the A.H.A. on smoking and its negative cardiovascular effects was in a similar vein.

Research and development efforts on the prevention of premature clinical coronary diseases:

In order to clarify this current situation, an analogy is useful, since it has considerable validity. The problem of preventive approaches to coronary disease stands today at the point where polio stood in 1953. By that time, the polio researchers had isolated the viruses, learned how to grow them, learned how to kill them without destroying their ability to provoke antibodies, had shown that this vaccine could be safely given, that it did not provoke antibodies in man and that it did protect monkeys against paralytic polio. "All" that had to be done was a mass field trial to test whether such a vaccine did protect children in the mass against the disease. The National Foundation, the Public Health Service, Dr. Jonas Salk, Dr. Thomas Francis, and their research teams did such a mass field trial and the results are history. Similar mass field trials are now needed to test the ability to achieve effective primary prevention of heart attacks by nutritional, hygenic and pharmacologic means.

The mass field trials needed in the coronary disease field are essentially similar in their basic principles to those needed for polio. However, specific features of the disease put a special stamp on the field trials against coronary disease. The preventive measures are not vaccines, rather changes in living habits; the subjects are not children, rather middle-aged men; the period of follow-up is not one summer, rather four to five years. These concrete aspects create unique problems for mass field trials on coronary disease and render them quite difficult.

Since 1957 pilot studies along this line have been in progress, and by now, considerable experience has been accumulated, in Chicago, New York, Cleveland, Los Angeles, and elsewhere. Our Coronary Prevention Evaluation Program in Chicago works longterm with high-risk men age 40-59. It strives to correct, and keep corrected — the decisive challenge — five abnormalities making for coronary-proneness, namely overweight, high serum cholesterol, high blood pressure, heavy cigarette smoking and lack of exercise. The research physicians and nutritionists work closely with the men and their wives to effect a permanent change in living habits, particularly eating, exercise and smoking habits. Short-lived efforts — the frequent American pattern of going on a diet, and then going off — are futile. A sustained reduction of high blood cholesterol and overweight, etc., must be achieved, if anything is to be accomplished in the way of preventing heart attacks.

The dietary approaches required to attain these goals have been worked out in great detail. In the language of nutrition, they involve diets moderate in total calories, total fats, polyunsaturated fatty acids and carbohydrates; low in saturated fatty acids and cholesterol; and high in all essential nutrients (proteins, amino acids, vita-

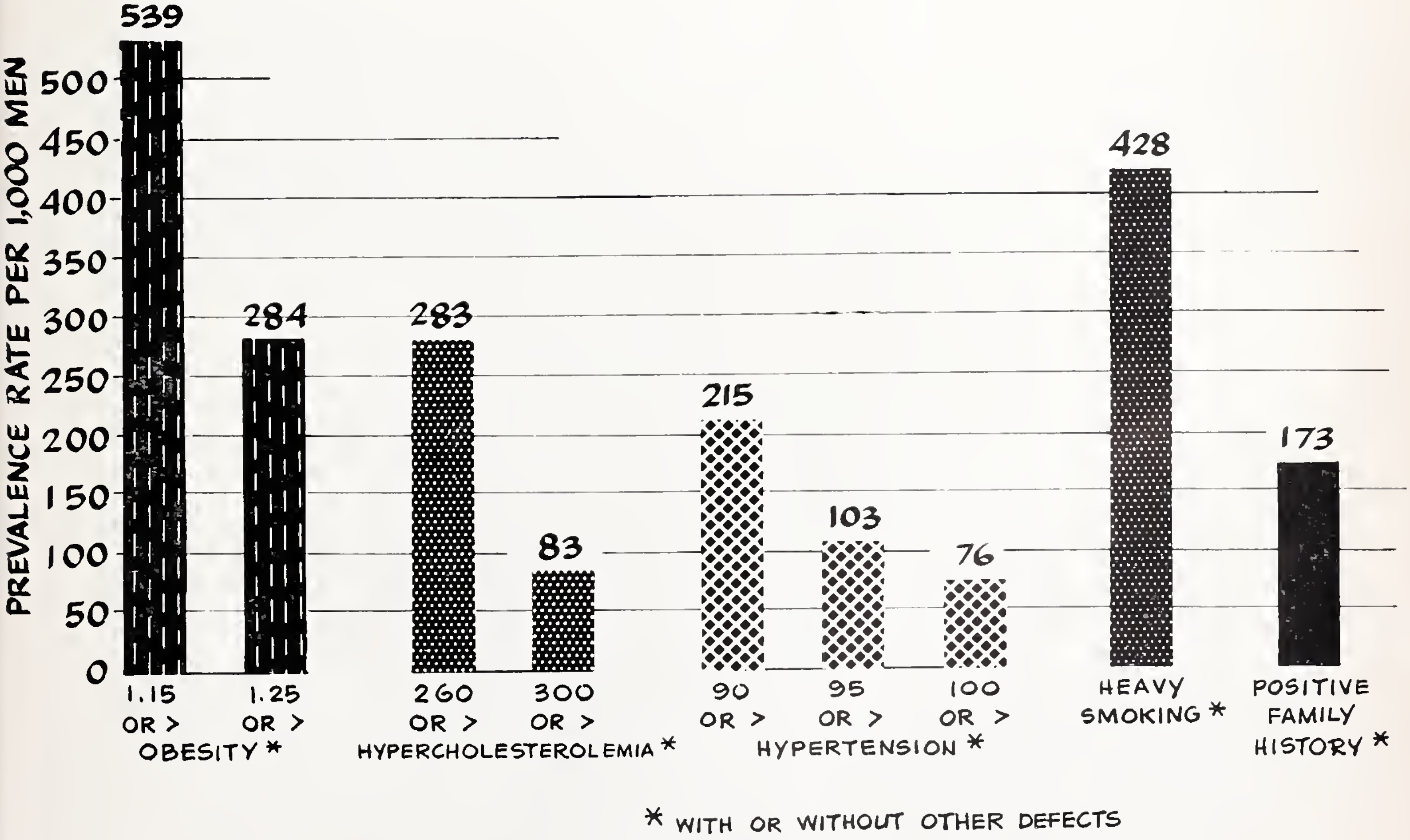


FIGURE 15

Prevalence of abnormalities associated with increased susceptibility to Coronary Heart Disease, 1398 men age 40-59 in 1958 without definite Coronary Heart Disease—Peoples Gas Light and Coke Company Study.

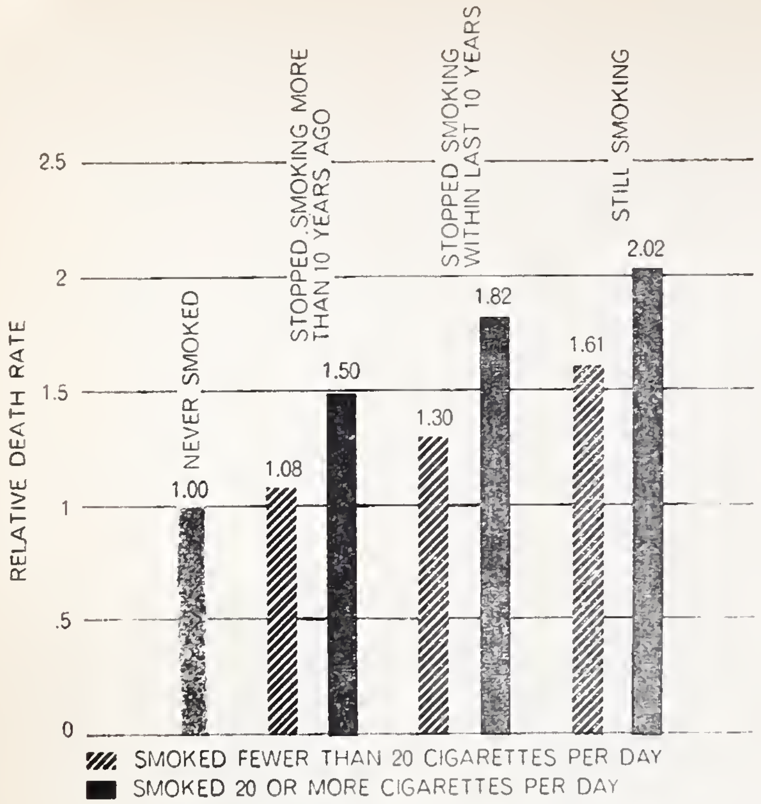


FIGURE 16

Relative death rates in former smokers, compared with persons who never smoked and with those who are still smoking, American Cancer Society Study.

mins, minerals) (Table 9). In terms of foodstuffs this means (Table 10):

Emphasizing the low-fat dairy products (skim milk, buttermilk, cottage cheese), and de-emphasizing the high-fat (sweet cream, sour cream, ice cream, whipped cream, cheeses, butter).

Emphasizing lean non-marbled cuts of meat and poultry, and de-emphasizing the fat marbled cuts, with trimming off fat before cooking, cooking so as to get rid of fat (broiling, rotisserieing, roasting with discarding of drippings, letting stews and soups stand in the refrigerator overnight and skimming off congealed fat); use of vegetable oils in braising or basting meats, etc.; moderation of meat portion size (four to six ounces, not twelve to sixteen!).

Emphasizing fish and sea food; de-emphasizing eggs.

Emphasizing vegetable oils, and de-emphasizing solid table spreads (butter, margarines) and solid shortenings (lard, suet, hydrogenated vegetable fats, drippings).

Emphasizing fruit desserts (citrus and non-citrus), and de-emphasizing commercial cakes, pastries, shortcakes, cookies and pies.

Emphasizing green and yellow vegetables and legumes (peas, beans).

Emphasizing moderation in use of starches (potatoes, rice, spaghetti, breads, cereals), carbohydrate-rich spreads (jellies, jams, honey, marmalade), sweets and alcoholic beverages.

Pages and pages of delightful and tempting recipes are available — to convince even the most skeptical that pleasure lies ahead along this way of good hope for the prevention of heart attacks. Indeed, one of the major lessons of the research experience to date is its demonstration that one of the pleasures of the good life — the pleasure of good eating — can and should remain as the effort proceeds to end the contemporary epidemic of premature heart attacks.

From the experience of the Coronary Prevention Evaluation Program to date, and similar

TABLE 9

Overall Changes in Daily Nutrient Intake
Total Experience of 99 Participants in Coronary Prevention Evaluation Program

Nutrient	Control	Treatment
Total calories	2465±692.4*	1668±334.4
Carbohydrate (gm.)	230± 73.3	192± 49.3
Protein (gm.)	106± 31.8	95± 17.1
Total fat (Gm.)	119± 42.7	56± 14.9
Saturated fatty acids (gm)	48± 19.0	19± 5.7
Unsaturated fatty acids	66± 23.5	34± 9.7
Polyunsaturated fatty acids (gm.)	16± 6.9	12± 4.6
Cholesterol (mg.)	627±219.7	307± 93.8
Percentage of calories from carbohydrate	37.7±7.1	46.3±6.3
Percentage of calories from protein	17.7±3.7	23.4±3.5
Percentage of calories from total fat	43.0±6.2	29.7±5.3
Percentage of calories from sat. fatty acids	17.3±3.3	10.1±2.3
Percentage of calories from unsat. fatty acids	24.0±3.5	18.3±3.4
Percentage of calories from polyunsat. fatty acids	5.8±1.9	6.7±2.0
Ratio: $\frac{\text{Polyunsat. fatty acids}}{\text{Sat. fatty acids}}$	0.36±0.15	0.80±0.33

*Standard deviation of the mean.

TABLE 10

Overall Change in Daily Intake of Food Groups—Total Experience of 99 Participants on Coronary Prevention Evaluation Program

Food Groups	Control		Treatment	
	Calories	Calories Percent Total	Calories	Calories Percent Total
Low fat dairy	44± 58.9*	2.1±2.9	134± 73.9	8.3±4.3
Medium and high fat dairy	202	7.8	26	1.5
Low fat beef, veal, lamb	32± 59.8	1.6±3.0	89± 69.0	5.6±4.4
Medium fat beef, veal, lamb	87±119.6	3.6±5.1	80± 72.5	4.8±4.1
High and very high fat beef, veal, lamb	309	12.6	105	6.1
Pork	169±178.0	6.6±6.2	56± 83.9	3.3±4.6
Poultry	81± 94.6	3.4±3.9	75± 51.8	4.7±3.2
Fish and sea food	33± 63.5	1.5±3.1	81± 67.9	5.2±4.3
Eggs	66± 5.0	2.8±2.1	8± 12.4	0.5±0.7
Bacon and lard	36± 53.3	1.4±2.0	10± 24.3	0.5±1.3
Butter and suet	116±103.5	4.5±3.7	15± 24.4	0.8±1.3
Margarine and hydrogenated oils	70± 78.6	2.8±3.0	24± 21.4	1.4±1.2
Oils and nuts	94± 88.8	3.9±3.6	124± 78.4	7.3±3.9
High fat baked goods	253±211.2	9.6±7.0	70± 89.4	3.8±4.2
Grains and starchy vegetables	433±139.2	18.3±5.4	409±113.7	25.1±5.7
Fruits and other vegetables	151± 79.8	6.6±3.9	205± 82.6	12.7±4.9
Sugar, candy, jellies, etc.	151±102.7	5.9±3.5	98± 65.7	5.7±3.3
Alcohol	136±206.8	5.2±7.5	57± 94.9	3.5±4.6

*Standard deviation of the mean.

studies, it is reasonable to conclude that a majority of high-risk middle-aged American males can be won for effective cooperation in an effort to prevent heart attacks. Moreover, there is no doubt that the cardinal risk factors can be corrected and kept corrected. Significant progress has also been registered in breaking the cigarette smoking habit, and in developing patterns of regular exercise.

Based on these positive experiences, and similar ones in New York, Los Angeles, Cleveland and elsewhere, a national cooperative study has been organized to explore further the feasibility of mass field trials to prevent heart attacks. The first studies along this line have been proceeding well for several months now. Grants have been awarded for this purpose by the National Heart Institute, close cooperation and support have been forthcoming from the American Heart Association and its affiliates, and work is proceeding in Chicago, Baltimore, Boston, Minneapolis and Oakland in this cooperative National Diet-Heart Study. A decade of hard work lies ahead to complete the overall job.

Perspective: This then has been a progress report, a report of significant advances by many investigators whose intensive efforts have been made possible by steadily increasing research support from the Heart Association and the National Heart Institute of the U.S. Public Health Service, that is, support from the American people via voluntary and tax dollars. But major research work remains to be done still, and with it a key question arises: What to do in the interim? What should medicine and public health at the "grass roots" do? What should the public generally do? Many signs point to the possibility of preventing heart attacks, but at the same time knowledge giving certainty is not yet in hand. And the mass field trials will certainly require the remainder of this decade, perhaps longer, before their results are available. Therefore the problem arises of an interim approach .

Two alternatives are possible. One might be called a more conservative alternative, and goes something like this: "All the new research information is very interesting and nice. It's good to see the research fellows making progress. We wish them luck. Admittedly, though, they haven't all the answers yet. In the meantime, therefore, we'll just wait and see." A corollary of this conservative wait-and-see approach is that no hope lies ahead for a major downturn in coronary disease incidence during the rest of the decade.

No hope lies ahead particularly for men of high risk.

The alternative approach is: "The facts point very strongly in certain directions. They indicate the possibility of prevention. Moreover, and this is very important, they indicate that this possibility can be achieved pleasantly and — even more important — safely, because the procedures involved, nutritional, hygienic and pharmacologic, entail minimal risks. The nutritional and hygenic measures under medical supervision are essentially risk-free. The drugs with which the medical profession now has a large experience; the risks with them are slight. Since the possibility of prevention exists, since coronary disease takes such an epidemic toll, since the possibility of achieving prevention involves safe procedures, and since — without these new approaches — particularly the higher risk individuals do, in fact, have every likelihood of suffering markedly and without surcease from heart attack, it would seem that a sound interim approach (particularly for the higher risk individuals) would be to attempt to take advantage of the possibility of prevention. This is, in essence, the position taken by the American Heart Association in its Statements, "Dietary Fat and Its Relation to Heart Attacks and Strokes" and "Cigarette Smoking and Cardiovascular Diseases."

What does this mean for medicine and public health across the country? First, it would seem to mean active leadership and participation in the expanding effort to assess risk and detect persons with asymptomatic sub-clinical coronary disease, particularly through use of periodic examinations including biochemical tests, electrocardiograms, etc. Second, it would seem to mean active participation and leadership in the development of prevention programs.

What, then, is to be anticipated? What are the possibilities for the years ahead? There is reason for cautious optimism. From 1920 until the late 1940's, the total death rate from all diseases of the cardiovascular system increased for white men age 45-54 in the United States. In the late 1940's the death rates stopped rising for the first time in over 30 years. Then in the early 1950's it began to dip, and from 1950 to 1960 a phenomenon occurred that has been overlooked and unheralded — an actual decline, modest but definite, in mortality from the cardiovascular-renal diseases, for all sex-race groups (Table 6). The toll is still great, but it may be that we are "over the hump."

In 1917, Chicago experienced 1216 deaths from diphtheria, many of them from diphtheritic heart disease. Who would have predicted then that in a few years this disease would be mastered and virtually eliminated.

In 1920, when rheumatic heart disease was a major scourge, who would have predicted that the death rate in children, teenagers and young adults would be so drastically that by 1959 it would fall to 10% of the 1920 figure. Yet that is what has been achieved.

It is not unrealistic, unreasonable or unscientific to suggest that these are portents of what lies ahead as a result of the mounting effort to prevent premature sickness, disability and death from atherosclerotic coronary heart disease. It is not unrealistic, unreasonable or unscientific for medicine and public health to be bold—in keeping with the best traditions—to set big tasks and ambitious goals, for "there is a tide. . ."

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CANCER SCREENING PROGRAM

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I. INTRODUCTION: Purpose of the Program

The Field Health Office at U.S.P.H.S. Alaska Native Health Hospital, Mt. Edgecumbe, designed a program to detect cancer and other gynecological disease among the female population of the predominantly Indian communities of Southeastern Alaska. This program was executed in several communities by the staff physicians on their field clinics and the itinerant public health nurses from the Alaska Department of Health and Welfare. The success or failure of this program was determined by the interest and resourcefulness of lay persons at the local level. The program as presented is thought to be suitable for any small community and may be of interest to Alaskan medical societies as well as USPHS field hospitals.

This program was designed with the goal of raising the standards of health among beneficiaries of the USPHS to the highest possible level.

The female cancer screening program was prepared with the following aims in mind:

1. To stimulate initiative and interest on the part of lay persons toward assuming more responsibility for their health.
2. To increase health information about preventable disease in the more isolated areas and to gather other health statistics.
3. To increase the clinical and preventive services of Alaska Native Health, USPHS, without significantly increasing the staff or material expenditures.

II MATERIALS

The listed materials were collected especially for this program. All were extremely useful and are recommended.

III. ORGANIZATION OF THE PROGRAM

The cancer flyer, "Health Council Project Number One," was mailed to all health councils in the predominantly Indian communities. After a health council indicated they wished to have the program, letters were sent to local physicians describing the program and stating that they may receive pap smear reports on some of their patients.

MATERIALS AND SOURCES USED IN FEMALE CANCER SCREENING CLINICS

LIST OF MATERIALS USED	SOURCE	AVAILABLE FROM
Educational		
Films:		
1. "Time and Two Women"	American Cancer Society and National Cancer institute	American Cancer Society Valentine Bldg., Juneau, Alaska
2. "Self Examination of the Breasts"	Same as above	A.D.H. Film Library, Alaska Office Building, Juneau, Alaska
Pamphlets:		
1. "If You Only Knew"	American Cancer Society	See above
2. "Breast Self Examination"	U.S.G.P.O., Washington, D.C.	A.D.H. Regional Office, Juneau, Alaska
Publicity mailed to the communities:	"Health Council Project Number One"	Field Health Office, Mt. Edgecumbe, Alaska (No charge)
Model of pelvis teaching	Ortho Pharmaceutical Co.	Raritan, N.Y. (No charge)
Clinical		
Vaginal speculae, disposable	"Sani-Spec"	Burnett Instrument Co. Lawrence, Kan.
Patient x-ray cape, disposable	Aloe, Div. of Brunswick, No. 78-4-3020	Seattle, Wash.
Patient drapes	Bed sheets	Provided by patients
Microscope slides frosted end and mailers	Usual supply houses	
Pap smear fixature solution		
Pap smear wooden spatulaes	Standard Ayre cervical scraper, No. A-2260	Clay-Adam, Inc., New York 10, New York
Disposable Tomac gloves	American Hospital Supply	

The itinerant public health nurse from the Alaska Department of Health & Welfare was also notified if the initial request of the health council did not come through her. The date was set and the place to hold the clinic was secured about one month in advance by the local health council. The dates selected were to coincide with the scheduled general medical field visits by the USPHS physician.

Slides were to be sent for examination to the USPHS Marine Hospital, Seattle, Department of Pathology, as usual. No special arrangements were made. Local medical societies may send slides without charge to USPHS, Washington Cytology Unit, Pembo Building, Room "R" 2654, Fourth and Independence Avenue, S.W., Washington, D.C.

After the physician's arrival, a health council meeting was held for planning the clinic. Local publicity in the form of posters and box holder mailings was done by the health council. Time and place was set for the films usually the evening before the clinic. Volunteers were signed up for registering patients, filling out tissue report forms, assisting patients on and off examining tables, arranging transportation for the aged, and cleaning up the clinic area.

During the films, the public health nurse distributed the pamphlets and answered questions with the aid of the pelvic model. The following persons were asked not to come:

1. Those who were pregnant now or within the last month.
2. Those who have had breasts and pelvis examined within the past year.
3. Those who have problems to be discussed privately.
4. Those below the age of 25 years, unless married.

In addition, patients were asked not to come for the pelvic examination who were menstruating.

After the film, patients were given appointments for the day of the screening clinic. Those with other problems were given regular medical clinic appointments.

The day of the clinic, a volunteer asked the questions below which were printed on the top of the form, "Tissue Examination," SF 515, USGPO.

1. How many times pregnant?
2. How many children delivered?
3. Did you have pelvic surgery? Yes...... No......
   If yes, why?..
   When?..
4. Any abnormal bleeding now? Yes...... No......
5. Date of last menstrual period?..........................

The public health nurse assisted the physician during the examination. The physician rechecked the answers and made corrections where necessary.

The Examination

The examination consisted of a breast inspection and palpation in a sitting and supine position with reiteration of the main points in the self-examination film. Next, a pelvic examination was done bimanually. Smears were made from the os and cul-de-sac secretions, labelled, and immediately placed in fixative solution for at least one minute.

In one community, a local resident registered nurse volunteered to do screening for hypertension and diabetes. During the cancer clinic, women here had blood pressures recorded and casual urine samples tested with combistix test paper.

The physician spent an average of 15 minutes per patient examination. Aged persons who had not been seen by a physician for one year were given more complete physical examinations.

IV. EXECUTION OF SCREENING CLINICS IN THE FIELD

During November, 1963, to May, 1964, five health councils requested the program for their community. Clinics were held in Craig, Klawock, Kake, Hydaburg, and Hoonah.

Craig—Cooperation of a local registered nurse, Mrs. Helen Hamilton, and the Craig health council resulted in a successful clinic in spite of severe weather, electrical failure, and lack of heat in the Craig Health Center. The patients persevered although the inside temperature was 42 degrees F. during the examinations. After the electric power was restored, a portable electric heater was found valuable to provide comfortable room temperature.

Mrs. Hamilton volunteered to screen each patient for blood pressure and glycosuria. Following the clinic, health council members collected statistical information on all adult women over 17 years in Craig.

Pap smears reports for non-beneficiaries were sent to their private physicians.

Klawock—A heavy snowfall made walking difficult, but the clinic was successful because of the great interest shown by the health council. A large classroom was used in the Klawock Independent School. For the purposes of the clinic, the health council constructed three plywood partitioned dressing rooms and examining tables. The new facilities also greatly expedited the usual medical field clinics. The health council interviewed all adult women whether or not they came to clinic.

Hydaburg—The screening clinic was less successful here in members attending. This was due to less publicity distributed locally by the health council; a severe blizzard the evening of the clinic; and the memorial church services for President Kennedy held the same day as the clinic; The clinic was held in the basement of the old grade school in two small rooms used by the public health nurse. An examining table with stirrups was used. No data was collected following the clinic about women not attending.

Kake—The clinic was held in the health center. Lack of advance publicity and conflicting local events were responsible for a low turnout. Ten women came for examination. There is an estimated adult female population of 80, of whom 40 might have been eligible to attend.

Hoonah—A screening clinic was scheduled for Hoonah in March and set up in the Sunday school rooms of a local church. Only five women attended. Reasons for the poor attendance were insufficient publicity for the clinic plus a last minute change of date since inclement weather delayed the physician's arrival by two days. Due to an unusually heavy general medical clinic, only one evening was spent at the screening clinic instead of the two planned.

V. ANALYSIS AND RESULTS

It would be presumptuous to draw conclusions based upon the small numbers in this sample. Of the 2,452 estimated total population of non-white females, aged 17 years and over, in Southeastern Alaska in 1960, information in Table III, for instance, is based on only 71 Indian women. This is only a 3% sample, and not a random sample at that. The following tables are presented as examples of analysis that can be done on information collected during the execution of cancer screening clinics.

Cancer Education

Number of Women Attending The Two Cancer Films

Craig	25
Klawock	32
Hydaburg	19
Kake	31
Hoonah	25
TOTAL	132

The films were well received and usually several questions were asked. They directly resulted in two patients later reporting for admission to the hospital for diagnosis. One had a benign breast tumor and one had functional uterine bleeding.

One additional cancer film was used for the grade and high school students entitled, "From One Cell," in Craig and Hydaburg. This film is about cellular reproduction in general, including neoplasms. The audience response was difficult to assess. The teachers thought the film was suitable.

Participation Rates

In Craig and Klawock, the 45 women not attending were asked their reasons by a member of the health council.

TABLE NUMBER II

REASONS FOR NON-PARTICIPATION

Reason	Number	% Total Not Attending
1. Pregnant	8	17.8
2. Had a recent pelvic exam	19	42.2
3. Minor illness	4	8.9
4. Other excusable reason (Menses, hysterectomy)	4	8.9
TOTAL EXCUSABLE REASONS	35	77.8
5. Other reasons unknown	10	22.2
TOTAL	45	100.0

The participation rate for those women eligible to be examined for these two communities was 44/54 or 81%. Of the 19 women who recently had been examined, 14 were seen at Mt. Edgecumbe within the past calendar year. This represents a surprisingly high percent of adult women hospitalized (14/89, 45%). Five non-natives had had examinations in Ketchikan Hospital or by other private physicians.

VI. DISCUSSION OF RESULTS

Pregnancy status of these women is difficult to compare with any other data gathered from female cancer screening clinics because of the small numbers and the paucity of published data from large series.

Breast disease was not found in this group of Indian women. The three abnormal findings were all in Caucasian females. However, in fiscal year 1964, at least 2 cases of carcinoma of the

TABLE NUMBER I

PROFILE BY RACE AND AGE OF TOTAL FEMALE ADULT POPULATION OF CRAIG AND KLAWOCK, AND OF ONLY THOSE ATTENDING THE SCREENING CLINIC IN HYDABURG

	HYDABURG		CRAIG				KLAWOCK				% Total Pop. of Craig & Klawock
	Attending		Attending		Not Attend.		Attending		Not Attend.		
	Ind.	Non.	Ind.	Non.	Ind.	Non.	Ind.	Non.	Ind.	Non.	
17 - 29	2	0	2	3	4	2	11	0	2	1	5.5
30 - 49	6	0	2	3	6	4	10	1	7	1	7.5
50 - 69	2	1	6	2	2	1	0	0	7	0	3.3
70 & over	0	0	3	0	1	0	1	0	2	0	1.1
Not stated	0	0	0	0	0	4	0	0	0	1	1.5
TOTAL ATTENDING CLINIC	10	1	13	8			22	1			
	(11)		(21)				(23)				
TOTAL NOT ATTENDING CLINIC					13	11			18	3	
					(24)				(21)		
TOTAL ADULT FEMALE POPULATION			(45)				(44)				
PERCENT TOTAL POPULATION OF CRAIG AND KLAWOCK			22.5				17.3				19.3

TABLE NUMBER III

PREGNANCY STATUS OF NATIVE AND NON-NATIVE FEMALES OVER 17 YEARS OF AGE IN THREE SOUTHEASTERN ALASKA COMMUNITIES — CRAIG, KLAWOCK AND HYDABURG

	NUMBER OF INDIAN WOMEN						NUMBER OF NON-INDIAN WOMEN		
Amt.	Number Pregnant	%	Delivered Alive	%	Abortions	%*	Number Pregnant	Delivered Alive	Abortions
None	5	7.0	5	7.1	48	72.7	2	3	8
1	4	5.6	4	5.7	10	15.2	3	3	2
2	5	7.0	6	8.6	3	4.5	1	1	1
3	4	5.6	6	8.6	5	7.6	4	—	—
4	9	12.7	8	11.4	—	—	1	2	—
5	9	12.7	12	17.1	—	—	2	—	—
6	8	11.3	6	8.6	—	—	—	—	—
7	1	1.4	4	5.7	—	—	1	1	—
8	6	8.5	1	1.4	—	—	—	—	—
9	5	7.0	5	7.1	—	—	—	—	—
10	5	7.0	3	4.3	—	—	—	—	—
11	1	1.4	2	2.8	—	—	—	—	—
12	4	5.6	3	4.3	—	—	—	—	—
13	1	1.4	2	2.8	—	—	—	—	—
14	—	—	—	—	—	—	—	—	—
15	—	—	—	—	—	—	—	—	—
16	3	4.2	2	2.8	—	—	—	—	—
17	1	1.4	1	1.4	—	—	—	—	—
Total Women	71	99.8	70	99.7	66	100%	13	13	11
Not Stated	5						10		
	76 Total Indian Females						**23 Total Non-Indian Females**		

*Number of abortions
Total number with at least one pregnancy x 100=per cent abortions

TABLE NUMBER IV

GRAVIDA OF 76 INDIAN WOMEN BY AGE

Age Gps.	Not stated	Zero	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten plus	Totals
15 - 24	—	3	2	—	1	1	2	1	—	—	—	—	10
25 - 34	—	—	—	—	1	6	3	3	—	5	1	—	19
35 - 44	2	1	—	2	2	—	2	1	—	—	—	5	15
45 plus	3	1	2	3	—	2	2	3	1	1	4	10	32
Totals	5	5	4	5	4	9	9	8	1	6	5	15	76

breast was diagnosed in Indian females at Mt. Edgecumbe Hospital. Therefore, it is well worth including the breast examination in a female cancer screening clinic.

The 33% incidence of cervicitis in the Indian women is greater than the 15% found in Larsson and Webb's group, but it is probably similar to the incidence in lower class urban populations. No smears were positive for carcinoma which is not surprising since the incidence is about 3 per 1,000 general female population. This disease does occur in the area served by Mt. Edgecumbe Hospital. Three patients with invasive cervical carcinoma were diagnosed during fiscal year 1964.

As a direct result of the cancer screening clinic, two patients were referred for surgery. A beneficiary had a large simple cyst of the ovary removed at Mt. Edgcumbe, and a non-beneficiary had a hysterectomy by her private physician for ulcerated intrauterine myomata. The class II patients had repeat smears on follow-up field visits and biopsies in Mt. Edgecumbe Hospital where indicated. Chronic cervicitis was confirmed.

SUMMARY AND CONCLUSIONS

A female cancer screening clinic program suitable for small communities has been described. The program was well accepted where sufficient publicity was distributed by the local health councils and when there were no conflicting local events.

Health information was collected, and examples of analysis were presented. Additional information may be collected if time and personnel permit. No conclusions about the health status of Southeastern Alaskan Indian women is warranted because of the small numbers. It is suggested that if this program is repeated in other areas, then similar information be recorded. With a larger sample, significant conclusions about gynecological disease can be achieved.

TABLE NUMBER V

FERTILITY RATE COMPARISON

RACE	Total Female Ages	No. of Native Women	No. of Children	No. of Children Ever Born per 1000 Women
1. Alaskan Indian	15-44	44	213	4,840
Southeastern	45 plus	32	183	5,718
		—	——	
		76	406	
2. Alaskan* Non-White (Exc. Negro)	35-44	12,534		4,837
3. North Dakota Non-White (Exc. Negro)	35-44	6,000		5,591
4. U.S. Total	15-44			2,736
Non-White (Inc. Negro)	45 plus			2,971
5. U.S. Total	15-44			2,251
White	45 plus			2,738

* From **Statistical Abstract of the United States**, 1962. Tables 58, 59 and 31.

Pathology Found

TABLE NUMBER VI

GYNECOLOGICAL PATHOLOGY IN SOUTHEASTERN ALASKAN WOMEN FOUND IN CANCER SCREENING CLINICS

1. BREAST	**Number**	**% of 71**
Normal	68	95.8
Chronic Mastitis	2	2.8
Post surgical carcinoma	1	1.4
2. PELVIC (Uterus)	**Number**	**% of 57**
Bimanual and inspection normal	27	47.4
Cervicitis and erosion	19	33.3
Fibroids	6	10.5
Hysterectomy	7	12.3
Stenosed cervix	2	3.5
Pregnancy suspected	1	1.7
PELVIC (Vagina)		
Senile stenosis and atrophy	4	7.0
Vaginitis	2	3.5
PELVIC (Adnexa)		
Salpingitis, chronic	6	10.5
Tumor	1	1.7
Prior ovarian surgery	2	3.5
Cystorectocele, moderate and severe	4	7.0
3. PAP SMEAR REPORTS		
Class I (Normal)	44	
Class II	12	
Class III and IV	0	
Lost slides	1	
4. HISTORY OF ABNORMAL VAGINAL BLEEDING	10	17.5

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President's Page . . .

JOSEPH B. DEISHER, M.D., President, Alaska State Medical Association

Dr. Deisher

Some of us who were disappointed with the results of the November election should stop to recognize that even if the conservatives had taken over at the Executive level of our nation, nothing would have changed very suddenly. Though an executive, an officer, a leader, may have very definite ideas of the path his organization should travel, he can modify, slow down, or accelerate the present course only gradually. The inertia of institutions is a ponderous thing. Proposed changes have to be carried out by committees and bureaus and the people who do the detail work and the routines. Once set in motion on a given course, momentum carries the programs along from one administration into another. This is good. The direction may be wrong, but the continuity is in final analysis, vital in producing results. In retrospect this continuity, this momentum, has been lacking in the Alaska State Medical Association for lo, these many years. For one thing, momentum is proportional to mass and we have been a small group. To promote continuity, the concept of President-elect was introduced into the Constitution. President, President-elect and any and all past Presidents must work together to promote continuity. With the help of the membership it can be augmented, and your Association built into the really effective social force that it **deserves** to be!

With the advent of statehood came the responsibilities of arranging our tribal institutions to function on a level paramount with the other states. Our State Medical Association now speaks with a voice of authority and prestige equal to that of any other State Medical Association, both within Alaska and nationally. It falls to the physicians and their official Association, then, to develop solutions for the health problems that beset our population and to advise our state government concerning the medical "sector" of our unique society. These problems include (1) Disaster Planning, (2) Mental Health Planning, (3) Adequate legislation for the licensing and control of medical practititioners, including intra-professional discipline as well as licensing regulations, (4) Recommendations concerning such things as Public Health Programs, adoptions, workmans' compensation. These by no means exhaust the list. Your Association has committees to cover these and many others. The problem arises in keeping the committees functioning—in continuity—with momentum. Much has been said about the responsibility of the physician to participate as a citizen in the political activity and the governing of his city, state, and nation. One of the best of introductions to the possibilities presenting on the political scene is to get oneself involved in an advisory study of some problem involving government. For the physician, a study of any one of the subjects mentioned above, could provide both a foot in the door to the mysteries of modern bureaucracy and, almost simultaneously, a kick in the pants for the doctor to correct the sadly deficient arrangements that soon are uncovered.

If the physician's image has slipped, it has skidded from that of a wise and kindly professionalism to that of a "medical merchant". The idealism of our younger selves has far too often been well overlaid with sorry cynicism. The application of our special knowledge and presumed intelligence to the problems besetting our localities and our state is an activity rather expected by our fellow-citizens. Interestingly enough, the problems involved can become a fascinating challenge if a little of the cynicism can be peeled off.

Our Association, too, is expected by the citizenry to perform certain functions. Without simple organization and without continuity of personnel and planning, the same preliminaries are chewed over again and again with a frustrating lack of results. Our Association has swung small weight in the past. Our members have decried our lack of results. Lack of continuity and repetitious preliminaries without solid entry into result-producing action has been behind this disconcerting inadequacy. Your officers, past and present, have wanted and have tried to do for and with the Association what the members have wanted done —or at least what they thought the members wanted done. Some of the time the members were unfortunately backward about informing the officers what was desired. In other instances the members of what should have been effective committees were not sufficiently experienced in the social machinery to know how to proceed toward the very desirable goals for which the committee was established. About the time they got oriented, the year was over and a new committee was set up for the next year.

Now, in 1964, and even more in 1965 and the years to follow, the Alaska State Medical Association can no longer afford the meaningless and fruitless resolution, nor a wishy-washy lack of stance that suggests lack of mature conviction. Still less can the **members** afford this unsatisfactory ineffectuality. Organized labor took a few years to find out how to operate, but, by heaven, they know now! Today organized labor obtains favorable legislation and executive favors. The leaders of organized labor have maneuvered themselves into a position to direct the activities of the "medical merchants" pretty precisely. Perhaps the Rank-and-File of medicine doesn't care, but I really think Old Rank-and-File does care. If I am correct, it may be worthwhile to examine what maneuvers are in order.

Our medical associations have been compared to the unions of the laborers and mechanics. The average citizen ascribes to them all the disciplinary and other powers that unions have—and also all their motives—and also an equivalent wealth. In this age of universal suffrage, perhaps it would behoove the professional people **in order to preserve their professionality,** to arrange to utilize, through their associations the advantages of unionistic methods, even to the extent of forming a Conference of Professional Organizations (CPO).

What particular Association actions am I trying to promote? I'll list them: (1) Professional **management** to replace voluntary, sparetime operation. No matter how experienced or dedicated he may be in Association processes, each of our members has first an obligation of making a living for his family and, second, of enjoying the living with them. Our collective concerns are important enough for us to hire professional management. Perhaps at first it will appear expedient to share the time and skill of a professionally trained executive secretary with another one or two professional associations in the state. Or perhaps a CPO could hire an adequate manager to work for and with the component groups. (2) If we want to play in this kind of league, salaries and operating funds are going to require increased dues or other **income.** ALASKA MEDICINE brings in a little profit—but only a little. Ask your carpenter, plumber, electrician or teamster hunting-buddies what dues they pay to their "professional societies". Measure what they get for their dollar against what you get for yours. Any solution or solutions come to mind? (3) The difficulty of maintaining **patient and persistent concentration** in seeking the goals of the Association is exceeded only by its basic necessity. The activity—the pointed drive—of the Association should be concentrated on two or three (rather than 20) projects at a time until these are well launched or achieved (not just a resolution passed). Active, durable committees to handle continuing problems, such as the negotiations with governmental agencies concerning fees, should take over some of the responsibility from the officers of the Association and should have a measure of continuity of personnel. Institutional plans and goals are realized only after 3 to 7 years of effort from initiation to beginning fulfillment. (4) Now is the time to begin to plan toward **permanent Association-owned quarters.** There are members of the Association with proven skill in the field of real estate. If some or all of these members of the Association got their heads together on this project, the permanent effectiveness of the Association could be, at one stroke, symbolized and enhanced by an edifice — the Alaska State Medical Association Building. How does that sound?

Look, fellas, instead of resolving to raise the salaries of the health personnel in the state government, which we cannot do, let's really go after solid results concerning 1 or 2 problems that are really ours to handle and **GET SOME RESULTS!**

MUKTUK MORSELS

A COLUMN DEVOTED TO
MEDICAL NEWS IN ALASKA

Compiled by

HELEN S. WHALEY, M.D.

GENERAL: It is a matter of considerable interest and concern that a number of the private physicians who have provided excellent medical service to their small isolated communities over a period of years are now contemplating leaving in the immediate future. Eagle River, ten miles outside of Anchorage and a growing residential community, lost the services of Dr. Marshall Simpson in July, and he has had no replacement. Dr. Bruce Keers of Kodiak will enter a radiology residency soon. Dr. Joseph Deisher of Seward, present State Medical Association President, and Dr. Jack Fenger of Homer, are negotiating for salaried positions on South Sea islands. Drs. John and Jean Chapman of Cordova are investigating further training in hospital &administration and public health medicine. Dr. Harriet Jackson Schirmer, Bethel's former mayor and first and only private physician, is moving to upstate New York. Dr. Carl Sandburg is leaving Sand Point next year for further professional training. All are seeking replacements for their communities with varying success. All of them will be a loss to the Alaskan medical group as they have represented outstanding examples of family or general practice type medical care.

Despite his isolation from a medical center, Dr. William J. Mills, orthopedist, Anchorage, has become an internationally recognized authority on frostbite and its treatment. To further this work he recently received a large grant from the United States Army which is to be used jointly with the University of Alaska for further research.

MENTAL HEALTH: The Mental Health Planning Commission, organized to set up guidelines for future mental health care in Alaska recently received Dr. Daniel Blain's preliminary survey report, the result of his one month consultation visit in August 1964. He is President of the American Psychiatric Association, and Director of Psychiatric Planning and Development, Pennsylvania Hospital. He felt that because of the isolation of Alaskan communities, it would be most feasible for preventive mental health care to be provided by individual physicians, whether in private practice or United States Public Health Service. He discussed a number of methods of offering further psychiatric training for the individual physician.

The Division of Mental Health has recently completed the staffing of the Psychiatric Outpatient Clinic Team in South Central Alaska with the arrival of Dr. Judith Ahlem to fill the post of psychiatrist. Dr. Ahlem, a graduate of the University of Southern California and a Fellow of the American Psychiatric Association, was associated for 35 years with the Livermore Sanitarium in California in the private practice of psychiatry. She is also a graduate of the Alfred Adler School of Medical Psychology and has taken post graduate training at the University of Vienna. In private life, Dr. Ahlem is the widow of Walter Nelson and the grandmother of ten children ranging in age from three to fifteen years old.

During October, a joint AAGP and Mental Health Association meeting was held in Portland, Oregon, to further discuss methods of offering general practitioners and internists guidance for the psychiatric counseling of their patients. This meeting was attended by psychiatrists, Drs. J. Ray Langdon, William Rader and Homer Ray; and general practitioners Drs. Bob Johnson, Kodiak and Royce Morgan, and Nancy Sydnam, Anchorage.

Dr. Joseph Deisher has been interested in supporting the Mental Health Program in the State of Alaska, particularly in Seward, for many years. With the recent Mental Health Planning Program under the Governor's Committee, Dr. Deisher organized a planning group in Seward. On November 30th, 1964, this group, broadly representative for the Seward Community, met at the Seward Episcopal Church with Dr. Barbara Ure, Coordinator for the Mental Health Planning. This was a very exciting and successful meeting and it looks like Dr. Deisher will be able to inspire his group to come up with some realistic plans.

ALASKA DEPARTMENT OF HEALTH: The cooperation of physicians is requested in a continuing study of Ewing's sarcoma by the Radiation Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland. Referrals of patients with a radiographic diagnosis of Ewing's sarcoma are needed. It is desired that such patients be referred prior to establishment of the diagnosis by biopsy in order that they may be admitted for biopsy and immediate institution of therapy. Physicians interested in having their patients considered for the study may write or telephone:

Dr. Ralph E. Johnson
Clinical Center, Room 6-B-09
National Institutes of Health
Bethesda, Maryland 20014
Telephone: 656-4000, ext. 6-5147

KETCHIKAN: Dr. Arthur Wilson, Jr., has returned to the practice of internal medicine in Ketchikan after a period in Oregon. The Wilsons are remodeling their office. Dr. Lewis Salazar continues to serve as the Alaska Native Service contract physician.

JUNEAU: Dr. J. W. Gibson, who has served as pediatrician at the Juneau Clinic for a number of years, has been appointed as part-time temporary head of the Division of Maternal and Child Health for the Alaska Department of Health. New temporary regional health officer is Dr. Joseph Rude, who will also continue with his general practice at the Doctors' Clinic. Dr. Robert Smalley, currently Chief of Staff at St. Ann's Hospital, passed his Boards in General Surgery in Portland, May 1964. Dr. Henry Wilde, cardiologist with the Juneau Clinic, recently passed his orals for the Internal Medicine Boards in Seattle. Dr. William Whitehead lost by a narrow margin his bid for re-election for the State House of Representatives.

FAIRBANKS: Dr. Edward Meyer, formerly Medical Officer in Charge of the United States Public Health Service Hospital in Anchorage, and for a number of years, an internist with the Fairbanks Medical and Surgical Clinic, was recently appointed to the Mental Health Planning Commission.

Dr. Reed Carroll, formerly of Mississippi and a graduate of John Hopkins' University, has joined the Fairbanks Medical and Surgical Clinic in surgery. Dr. Ancel Earp, Jr., a member of the American Board of Surgery and formerly on the staff of the University of Oklahoma Medical School, has joined the Tanana Medical and Surgical Clinic.

Dr. Nicholas Deeley is touring many of the interior Native villages and doing physical examinations on the children, while accompanying Bishop Gordon on his flights.

CORDOVA: The Doctors Chapman attended postgraduate courses in San Francisco in November.

SOLDOTNA: In addition to covering practices for a number of other physicians so that they could take vacations from their small communities, Dr. Paul Isaak attended the annual Heart Meeting in Atlantic City, as President of the State Heart Association. He and Dr. Gaede have both recently covered Cordova and Homer.

SEWARD: Dr. Joseph Deisher, in addition to his duties as State Medical Association President, attended a Disaster Planning Meeting in Chicago in October.

HOMER: A symposium on Arteriosclerosis as attended by Dr. John Fenger in Seattle, under the auspices of the Alaskan Heart Association. Dr. Fenger is also active on the Homer City Council.

ANCHORAGE: Dr. Duane Drake. who went to the University of Minnesota in October for a symposium on "Tumors of Infancy and Childhood", was accompanied by his wife. Dr. James Coin attended a radiology meeting in Chicago. Dr. Glenn Crawford participated in the University of Washington course on pediatrics in December. Dr. Charles Chenoweth recently returned from his annual postgraduate sessions in Iowa. Dr. Merritt Starr is vacationing in Acapulco, Mexico.

On December 30, Dr. James Walter Coin married Rose Aline Vowell in Anchorage. The reception at the home of Mr. and Mrs. James Power was attended by many of the physicians in the Anchorage area.

New officers of the Anchorage Medical Society include; Dr. Lester Margetts, President; Dr. Theodore Shohl, President Elect; and Dr. Gilbert Blankenship, Secretary-Treasurer. Dr. Shohl is the new Chief-of-Staff at Providence Hospital with Dr. J. Ray Langdon the designated Chief-of-Staff for 1966.

WANTED: M.D. to share practice in Kodiak, Alaska's oldest, most promising and prettiest community; population 3500 and growing. Must be general practitioner or general surgeon willing to do some general practice temporarily. Equipped clinic facilities available for rent. Separate billing and separate practice as desired. Community Hospital, nineteen beds, with complete x-ray and laboratory services. Forty-five to fifty-hour week. Home for lunch. A challenging country and a challenging practice. Contact R. Holmes Johnson, M.D., Box 1727, Ph. 486-2171.

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